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ABSTRACT

This handbook provides practical information about the special needs of adult students (especially in literacy programs) who are being treated for mental disorders. The handbook includes teaching strategies for meeting these needs, as well as basic information about mental disorders and their treatment. The handbook is divided into six chapters that cover the following topics: (1) mental disorders and treatments; (2) the mental health system; (3) memory and mental disorder; (4) problems and strategies for literacy coordinators and instructors; (5) problems and strategies for students; and (6) training tutors of people with mental disorders. The guide also contains the following: a word list and glossary of terms; a resource guide listing books, articles, videotapes, newsletters, and organizations concerned with teaching adults with mental disorders; and 127 references. (KC)

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ED 384 710

Just Ask!

a handbook for instructors of students being treated for mental disorders

by Howard Davidson

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If you have come to help me you are wasting your time.
But if you have come because your liberation is bound up with mine
then let us work together.

Lilla Watson
An Australian Aboriginal woman

ACKNOWLEDGEMENTS

TWO students deserve full credit for the idea of creating this handbook. In 1989 they attended a workshop which I conducted for tutors teaching people who were being treated for mental disorders. These two students were at the workshop because they felt that their literacy program was not meeting their needs. During the coffee break, they asked me if I could write a book that would help literacy workers teach people like themselves. The concept for the book is theirs and I hope it serves the purpose which they intended.

It took two years to gather information for the handbook because I wanted to tap the experiences of students receiving treatment for mental disorders and their instructors. To accomplish this I interviewed many students, literacy workers, and mental health workers. Rules on confidentiality prevent me from mentioning their names. To those students and literacy workers, let me express my sincere gratitude for their support.

I am able to acknowledge the contribution of the staff at Highwood School for sponsoring this project, especially Helena Storrie and May Diver for helping to secure and administer the grant. Two psychiatrists, Drs. Margaret Tweddle and Alan Gordon, and Linda Ongaro, a pharmacist, all at Alberta Hospital Edmonton, patiently read and revised several drafts of the handbook to ensure the accuracy of information about disorders and treatments. I also want to thank Gerald Robertson, professor of law at the University of Alberta for assisting in the difficult task of describing patients' rights. Finally, I want to thank Marcia Stentz for her good advice and countless hours of support.

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INTRODUCTION

JUST ASK: A HANDBOOK FOR INSTRUCTORS OF STUDENTS BEING TREATED FOR MENTAL DISORDERS provides practical information about the special needs of adult students who are being treated for mental disorders. The handbook includes teaching strategies for meeting these needs, as well as basic information about mental disorders and their treatments. It has been written for people with no previous knowledge of psychology or mental disorder.*

While the handbook is written for adult educators, mental health workers will also find it useful. Although they know a great deal about mental disorders and treatments, mental health workers will discover what students and instructors have learned about the adverse effects disorders and treatments have on learning, and what they can do to support the student's effort to participate effectively in literacy or other adult education programs.

While the handbook focuses on the needs of individuals studying in literacy programs, it may be useful for minimizing difficulties that arise in other settings and social situations. It speaks to a variety of people who need to understand how mental disorders and treatments affect the ability of an adult with special needs to learn and participate fully in a wide variety of social activities.

Overview of the handbook

The handbook is divided into six chapters. Chapter One contains basic information about the characteristics of seven mental disorders, their treatments, and the effects of both disorders and treatments on learning. The disorders are schizophrenic disorder, paranoid disorder, depressive and manic-depressive disorders, anxiety disorders, substance abuse disorders, and brain injury disorders. For the most part, the treatments discussed are medications. While there are other types of mental disorder and many treatments which do not involve the use of drugs, these seven disorders and their medications appear to create the most common difficulties for students.

* In order to make the handbook 'user friendly', sentences are not interrupted by footnotes and references to articles as they would be in a more technical book. However, all of these articles and books have been listed in a bibliography at the end of the handbook.

Because those who work with students being treated for mental disorders find themselves involved with more than just disorders and drugs, Chapter Two provides information about the 'mental health system'. This includes an overview of different psychiatric facilities, duties of mental health professionals, various treatment methods, patient's status in hospitals, and patient's rights.

Memory, the ability to store information and to retrieve it is essential for learning. Anything which interferes with a person's ability to remember is going to hinder her/his ability to improve literacy skills. Thus Chapter Three focuses on memory and how it is affected by the various mental disorders and treatments. Because it contains essential information on the effects of disorders and treatments on memory, it is best to read Chapter Three before reading subsequent chapters, which describe the learning needs created by specific mental disorders.

The final three chapters of the handbook are concerned specifically with effects of mental disorders and of treatments on learning. Chapter Four identifies needs of the instructor and recommends strategies for meeting them. These include such difficulties as the struggle to avoid becoming a therapist and concerns over the use of controversial reading materials. Chapter Five identifies the specific needs of students and strategies for meeting them. Of course, one need may be closely related to another, and often several needs can be met with one strategy. A section called 'Also See', which follows each need, will send the reader to related needs and strategies in Chapter Five. Finally, Chapter Six suggests how tutor trainers can include in their training courses a component on working with students being treated for mental disorders.

For those readers who want more information about topics contained in the handbook, a Resource Guide at the end of the handbook provides a list of books, articles, pamphlets, films, and videos.

How to use the handbook

This handbook is not intended to be read from front to back. Instead, readers can identify a concern and refer to the handbook for information and suggestions. The Table of Contents provides a guide for doing this. The following illustrates how the handbook can be used.

For a few weeks a student comes to work with her tutor and her hands are shaking. The shaking becomes a concern because it is very difficult for the student to write and she is upset because the tutor notices it.

The tutor consults the handbook. He turns to the Table of Contents and finds Tremors in Chapter Five. He turns to this entry (page 136) and learns that it is a side effect caused by several types of drugs used to treat mental disorders. He also reads about some strategies to minimize difficulties created by the tremors.

The entry on Tremors refers to antipsychotic and antidepressant drugs. Once again the tutor turns to the Table of Contents and finds Chapter One, Mental Disorders and Treatments. In this chapter information about drugs, like antipsychotics and antidepressants, and their side effects, like tremors, is available.

He thinks it is important to discuss the shaking with the student; however, he does not feel comfortable raising the subject of mental disorders with her. If this is a concern, he should turn to Chapter Four where he will find a section called Discussing Mental Disorders with Students.

Having consulted the handbook, he is prepared to speak openly with the student about the shaking. He has some background information which helps him to ask questions and listen to her talk about her mental disorder and treatments. During their talk she may raise other concerns. For instance, she wants the tutor to act as her advocate in getting her doctor to change her medications. This concern and many others are also discussed in the handbook and can be found by consulting the Table of Contents. If the tutor and the student want additional information, they should turn to the Resource Guide.

The handbook also contains a Glossary which defines the most important terms used in the handbook. Following each term is the page number where it is described in greater detail.

Literacy coordinators and instructors may want to read through the handbook for information that will alert them to concerns which may arise from time to time. Chapter Three, which treats memory and the effects of disorders and treatments on it, is best read before reading Chapters Four and Five, which describe more specific needs and strategies. Tutor trainers should read Chapter Six before they prepare their training programs. They may want to duplicate sections of the handbook as course materials. This is acceptable without obtaining the publisher's permission.

The origins and development of the handbook

Two students deserve credit for the idea of creating this handbook. In 1989 I was invited by a coordinator of a community-based literacy program in Toronto, Ontario to conduct for tutors a workshop on teaching students being treated for mental disorders. The two students were at this workshop. They lived in the community, attended literacy classes, and were being treated for schizophrenia. They came to the workshop because they felt that the literacy program was not meeting their needs. During the coffee break, they asked me if I could write a book that would help literacy workers to teach people like themselves. The need for a book like this was obvious to them.

I shared their idea with tutors at a second workshop on the same topic and they liked it. Not until the idea was presented to the staff at Highwood School in Edmonton, Alberta did it begin to be realized. Highwood School offers an adult education program for people being treated for mental disorders at the Alberta Hospital Edmonton. Their staff offered to sponsor the development of the handbook and we received a grant from the National Literacy Secretariat. The project was under way.

It took two years to gather information for the handbook because I wanted to get most of the information from students who were being treated for mental disorders, their instructors, literacy program coordinators, and mental health workers. Twenty-three students discussed the difficulties they faced in the classroom and how certain teaching strategies either improved or hindered their abilities to learn. Fifteen instruc-

tors and program coordinators identified students' needs from their points of view. Instructors also talked about their own special needs which come to the fore when they try to teach students treated for mental disorders.

The mental health workers interviewed included psychiatrists, social workers, psychiatric and community nurses, a pharmacist, a community advocate, and a lawyer. These people provided information about characteristics of mental disorders, side effects of treatments which are likely to create learning difficulties, community living issues, advocacy for patients, and patients' rights.

Many of the comments made by those who were interviewed are repeated in the handbook. In this way, they speak directly to the reader about their experiences and their efforts to overcome the difficulties they have faced. Changes in their comments have been made to preserve people's privacy and in some cases to clarify the remark.

Information for the handbook was also taken from articles and books. A great deal has been written by and for psychiatrists, psychologists, and other therapists about the adverse effects of mental disorders and treatments on learning. Because these writers assume that their readers have an extensive background in psychology and because their interest is in treatment, the information is not very helpful to instructors and students. With the assistance of psychiatrists and a pharmacist, I was able to identify and summarize essential information in these books and articles and combine this with what I had learned from speaking with students, instructors, and mental health workers. Thus, the content in the handbook draws on people's personal experiences and published research.

About the title

Just Ask is the title for this handbook because it conveys an important message. The two students who conceived the idea of making this handbook, and every student and instructor I interviewed, said that a successful educational experience depends on the willingness of both learners and instructors to talk openly with each other about their respective needs. While the characteristics of some mental disorders and the side effects of many drugs used to treat them have a profound adverse effect on learning, these are not the only or greatest barriers to learning. An unwillingness to speak openly, for whatever reason, creates the greatest obstacle. Just ask, and if for some reason the person does not want to answer, then respect her/his decision to keep information private. I can think of no better way to stress the importance of open communication between student and instructor than to emphasize this recommendation through the title of this handbook.

Important concerns

Underlying the information in the handbook are important concerns about the nature of mental disorder and the ability of mental health workers to detect and treat it. Many people interviewed expressed serious concerns about the potential abusiveness of therapies and the extent to which therapies have been used to manage and control

people living in institutions. There are numerous cases in which individual's rights have been violated, sometimes merely to make operating a hospital or prison easier for the institutional authorities.

Those who take a very strong position against the value of psychiatric treatment, especially the use of drugs and electric-shock therapy, will probably feel that the handbook does not contain enough information about the serious side effects of these treatments and the existence of alternative care. Still others will find that the handbook is too critical. While working on the handbook I have listened to many sincere people express a wide range of opinions on this and other issues. I could not consider all the issues they raised, and so the reader is encouraged to use the material in the Resource Guide to learn more about them.

Two controversial issues have affected the handbook and so they need brief explanation. The first concerns the nature of mental disorder, whether mental disorder is truly a disease. The second concerns the nature of treatments for mental disorders, their effectiveness and validity.

THE NATURE OF MENTAL DISORDER

The handbook does not refer to students as having a mental disorder, but rather it refers to 'people being treated for mental disorder'. This distinction recognizes that there is no consensus about the nature of mental disorder, in particular whether or not it is a disease, i.e. mental illness. Many contend that it is not, but that calling it an illness is an indication of intolerance for differences or even a way to control people who threaten the status quo.

Pamphlets published by the American Psychiatric Association and the Clark Institute of Psychiatry - listed in the Resource Guide - believe that what we are talking about here are illnesses. This quote from one of the Association's brochures is an example.

> *Researchers have made tremendous progress in pinpointing the physical and psychological origins of mental illness in the past 25 years. Their studies increase accurate diagnosis and treatment for these illnesses (American Psychiatric Association, 1988: 3-4).*

Ex-psychiatric patients have organized a collective called On Our Own, which for many years published a magazine called *Phoenix Rising*. Contributors to this publication and others like it have a different perspective. In an issue which reports on the '11th Annual International Conference For Human Rights and Against Psychiatric Oppression', a position of the 'psychiatrized' on mental disorders was put forth.

> *At least 30 people, chiefly ex-psychiatric inmates together with three or four non-inmate supporters, walked in turn up to the open mike to deliver very personal, political and often moving testimony.... They spoke the truth about what it's really like to be forcibly incarcerated, abused and brain-damaged by psychiatrists; the truth about what it's like to lose our human and civil rights under the guise of treatment; the truth about how both*

psychiatry and psychiatric institutions humiliate and invalidate us (Weitz, 1983: 15).

Anyone who thinks these comments can be dismissed as extreme should turn to *The Dictionary of Psychology* where a definition for mental disorder seems to recognize the concerns expressed by Weitz. It defines mental disorder as:

> *A more neutral term than either mental disease or mental illness, and preferred by many because it does not convey the assumption of the medical model of clinical phenomena...(Reber, 1985: 434).*

The handbook uses the phrase 'people being treated for mental disorders' in order not to 'take sides' on this issue. It provides information which instructors and students can use to form their own opinions. The problem, however, is to avoid using words which imply that we favour a particular perspective. The phrase 'people being treated for mental disorders' is used because regardless of one's point of view - that mental disorder is an illness, a social condition, or a form of oppression - we can agree that a student is being treated for a disorder. Whether she/he should or should not be treated is open to question.

THE NATURE OF TREATMENT

Let me pose this concern by telling a story about the development of the handbook. After I wrote a first draft of the handbook, I gave it to two mental health workers for their feedback. In Chapter One there is a section on treatments for manic-depressive disorder which describes the adverse effects of a drug called Lithium. The description of Lithium's side effects and people's concerns was based on an article which said that many adults refuse to take Lithium because it affects their memory and causes confusion. This seemed worth reporting, but the first mental health worker disagreed, describing the comment about Lithium as 'picking' on the drug. I was advised to use greater restraint. To my surprise, the second mental health worker made no mention of the reference to Lithium.

When I told this story to a third mental health worker, she indicated that there was nothing peculiar in my story. She assured me that there is a great deal of controversy over the effects of Lithium, as there is with most drugs and other forms of treatment. Research continuously changes opinions of mental health workers. Personal experience, for instance, will affect how each therapist judges the merits and drawbacks of a drug or any therapy. The effectiveness of any one treatment is not a timeless truth written in stone.

Some might say that this story is a good example of how psychiatric treatment is just personal opinion, or worse. Indeed, there are many important studies, mostly conducted by psychologists, which show clearly the fallibility of medical knowledge and the influence of personal bias on psychiatric treatment. However, I think this response misses the point.

This story and others like it should remind us of the fact that our knowledge about ourselves and the world in which we live is rarely if ever right or wrong. Most often, we

are somewhere along the way in knowing more about this or that. Sometimes we take directions which do a great deal of harm; frequently we refuse to change directions because we get too committed to our beliefs. I think this story suggests that our knowledge about mental disorder is no different.

What does this mean for the accuracy of the information in this handbook? Is the information correct? Can it be trusted? The best answer is that this information was offered sincerely by people who have spent a great deal of time living with and studying mental disorder. They did not all agree with each other. That is why the handbook contains a variety of descriptions about students' needs and even greater variety in the strategies recommended for meeting them. And to avoid the common assumption that psychiatrists and other professionals always know best, the comments of students, instructors, and mental health workers have been treated equally: what a student has to say about her/his experiences as a student is as useful for us to know as the experiences of instructors and the outcomes of research.

Concluding remarks

In conclusion, I would like to encourage those who use the handbook to add materials to it from any sources that offer valuable information. Perhaps the most important additions will be notes and comments from students, instructors, and health workers. Indeed, the handbook has weaknesses, but it will be strengthened and made more useful if readers draw on their own experiences as they implement recommended strategies.

The first strategy I recommend is that the instructor turn to the title; then turn to the student and *Just Ask*.

Chapter One
MENTAL DISORDERS AND TREATMENTS

IF you are working with a person being treated for a mental disorder, you need to be aware of how the disorder and treatment may adversely affect someone's ability to learn. Students, instructors, and psychiatrists identified five mental disorders which should receive your attention. These are schizophrenic and paranoid disorders, mood disorders, anxiety disorders, substance abuse disorders, and brain injury disorders. Although many types of therapy are used to treat these disorders, the focus here is on drug therapy because it is the most common form of treatment and the one most likely to create additional learning problems. Therefore, this chapter is divided into five sections, one for each group of disorders. In each section these four questions are answered.

- What are the major characteristics of the disorder?
- How does the disorder hinder learning?
- What treatments are used to treat the disorder?
- How do the prescribed treatments hinder learning?

Schizophrenic and Paranoid Disorders

A psychotic disorder is a severe mental disorder. Schizophrenia and paranoia are both severe mental disorders, schizophrenia being the most common psychotic disorder. Schizophrenic disorder is actually a group of disorders in which the primary characteristics are disturbed language and communication, thought, and perception which last longer than six months. Compared to other psychotic disorders, schizophrenia causes the greatest degree of disturbance and it is the most difficult to treat. About half of the people hospitalized once for this disorder will be hospitalized again within two years.

What are the major characteristics of schizophrenic disorders?

PHASES

The disorder moves through phases.

- The **onset phase** is a noticeable deterioration in social skills. It becomes difficult for the person to work, study, and spend time with friends.
- The **acute phase** is marked by delusions, hallucinations, and distorted thinking.
- The **remission phase** is when the distortions have passed, but the person may lack 'spark'. Feeling tired, finding it hard to concentrate, having little motivation, and wanting to be alone are the striking characteristics of a person during this phase. The person may function normally but not as effectively as before the onset of the disorder.

A person may experience only one acute phase in her/his life or move through the phases often and in cycles. This makes schizophrenia hard to treat because people in the remission phase may feel well enough to stop taking their drugs in order to avoid the unpleasant side effects. This may cause the acute phase to reappear.

During an acute phase people may experience delusions, hallucinations, and various forms of thought disorder. What are these experiences like?

DELUSIONS

Delusions are fixed, false beliefs. A person is delusional when she/he believes something despite anything which tells her/him that it is not true. People who believe they can fly are delusional. A delusion is not rational and so a person cannot be convinced that it is not real. Here is an example.

> *"We were sitting playing cards. I was sure she could see the cards in my hand. She could tell what I was thinking, everything. I quit [playing] but that didn't matter. She could read things and find out what kind of person you are. She knew everything, and it didn't matter if I stayed there or left the room."*
>
> *"Could I help you to see that it isn't true?"*
>
> *"You can't argue, if that's what you mean. It wouldn't bother me if you tried, or anything like that. I just wouldn't listen."*

HALLUCINATION

Experiencing a sight, sound, smell, or feeling which is not there is a hallucination. Hearing voices is the most common hallucination. The voice may comment on the person's behaviour, offer advice, or make commands. An example is hearing voices from 'the command control centre.'

THOUGHT DISORDERS

A person suffers from thought disorder when her/his thoughts no longer connect in a way that makes sense to others. Thoughts may come in a random order. Ideas are jumbled. Statements may lack content. An example is this comment: 'I'm hungry. All animals have eyes, you know, like snow. Can I get something to eat? Let's talk.' The person may describe thoughts as alien: 'That's not my thought. That was put in my head.' Or, the experience may be that thoughts are 'stolen'.

Other characteristics of schizophrenic disorder are:

- unexplainable changes of emotion.
- an inability to make decisions about minor problems.
- a tendency to withdraw or become suspicious.
- lack of insight and poor judgement.

Delusions, hallucinations, thought disorders, and the other characteristics of schizophrenia usually do not cause someone to lose all touch with reality. For example, students hearing voices can continue to study. However, when the disturbances become what psychiatrists call 'florid' (what is commonly called 'a bad day'), they can interfere with daily activity. For example, in class a student 'hears' a voice and he begins talking to it. Another person in the room gets angry because the student is 'talking to himself' and tension develops. This can make it very difficult for the hallucinating student to take control of her/his situation.

What are the major characteristics of paranoid disorders?

A paranoid disorder is a psychotic disorder which is characterized by slow development of complex and elaborate delusions based on distorted interpretation of actual events. Typically, paranoid disorder involves three kinds of delusion.

- **Persecutory delusion**
  the belief that other people or things are trying to harm her/him.
- **Grandiose delusion**
  the belief that she/he is a supernatural being or some famous person.
- **Irrational jealousy**
  the belief that she/he cannot trust the affection of a loved one.

How do schizophrenic and paranoid disorders hinder learning?

Studies have identified the adverse effects of schizophrenic and paranoid disorders on learning, although it has not always been possible to tell if the difficulties were caused by the disorders or by the side-effects of drugs used to treat the disorders. Most studies conclude that learning difficulties are affected by a combination of the disorder and the drug side-effects. New research which actually lets us see the brain functioning indicates that the disorders are caused by physical changes to the brain. These changes may be responsible for learning difficulties.

Box 1 Types of Paranoid Disorders

The following three types of paranoid disorder involve combinations of persecutory delusions, grandiose delusions, and irrational jealousy.

Paranoia

This type combines jealousy and either delusions of grandeur or persecution. A person's mental abilities are not affected by paranoia. She/he is usually able to behave in a manner which is accepted by others.

Acute paranoid disorder

This type combines jealousy and persecutory delusions. It lasts for less than six months. Usually it appears quite suddenly. Commonly it follows a serious upset in a person's life.

Paranoid schizophrenia

This type combines any delusion with hallucinations or thought disorders. Therefore, it has characteristics common to both schizophrenic and paranoid disorders.

Some learning problems which seem to be caused by the disorders are as follows.

ATTENTION AND PRACTICE DEFICITS

Anything that is done repeatedly and almost automatically requires little attention to be learned. Learning the words and tune to a song heard over and over again on the radio is an example of learning which requires little attention. Other tasks such as reading require more effort to learn. Hallucinations, delusions, and thought disorders make learning that requires effort difficult because the person's attention is distracted and practice is interrupted. And tasks which are normally learned almost automatically require more effort because the student must overcome the distractions.

POOR ABSTRACT THINKING

The ability to think abstractly is diminished by schizophrenic and paranoid disorders. Students have trouble understanding such abstract concepts as why and how things are grouped into categories. If asked concrete questions, the student can provide a good answer, but questions which require abstract thinking cause trouble. For example, if asked to name the hero of a story, the student will do so successfully. But if asked to compare the hero in one story to the hero in another, she/he is unlikely to give a good response.

POOR PLANNING AND PROBLEM SOLVING

The ability to plan ahead, solve problems, and perform daily tasks efficiently is impaired by delusions, hallucinations, and thought disorders. These characteristics of schizophrenia create an over awareness of sights, sounds, and thoughts. Unable

to filter out these distractions, the student is constantly side-tracked. The purpose of the plan, the plan itself, or the problem to be solved are forgotten or lost in a maze of unrelated ideas.

POOR MEMORY

Memory is a complex process of storing and retrieving information (See Chapter Three). Schizophrenic and paranoid disorders create problems for both storing and retrieving information. The disorders affect the ability to remember concepts related to time and space. Short-term memory is also impaired. For example, if a student learns to read a list of words and a few minutes later is asked to read the list again, usually she/he is unsuccessful.

WEAK ORGANIZATIONAL SKILLS

Organizational skills include working at a task systematically, recognizing a sequence, and putting things in an order. Listing words alphabetically or following a step by step procedure to solve math problems are examples of using organizational skills. Persons being treated for schizophrenic and paranoid disorders often show weak organizational skills. Hallucinations, delusions, and thought disorders interfere with the concentration needed to recognize and follow a sequence.

WEAK VERBAL SKILLS

Verbal skills, the ability to do things with language, are essential for reading and writing. On reading tests, people being treated for schizophrenic and paranoid disorders show weak verbal skills. Drawing pictures, assembling puzzles, and other tasks which require physical coordination are affected less than tasks involving word recognition, reading comprehension, and the ability to solve math problems.

What is the common treatment for schizophrenic and paranoid disorders?

Drug therapy is the most common form of treatment and the one which has both positive and negative effects on learning. The group of drugs used to treat psychotic disorders are called antipsychotic drugs. Antiparkinsonian drugs are used to treat side effects caused by the antipsychotic drugs.

Learning may improve with the use of antipsychotic drugs because the drugs reduce the delusions, hallucinations, and thought disorders which cause poor concentration and distractions. Students find it is easier to pay attention, practice, and organize their activities when their thoughts are not being disrupted. Knowing how the drugs work can help to explain how they can improve learning ability.

ANTIPSYCHOTIC DRUGS

It is believed that antipsychotic drugs (also called neuroleptic drugs) act like a filter on the nervous system. The filter works by sedating the person's senses. With less

information coming in, the person is less likely to experience delusions, hallucinations, and thought disorders. Therefore, antipsychotic drugs do not cure the disorder; they control or mask the troublesome characteristics.

Antipsychotic drugs do not work immediately. Some reduce major disturbances in the first week of treatment, but it may be one to six weeks before delusions, hallucinations, or thought disorders are reduced or stop.

Like all medications, every antipsychotic drug has two names: a generic drug name, which is its scientific name, and a trade drug name, which is its common name. Mental health workers and people being treated with these drugs use both names. To make things more complicated, Canadian and American trade names for the same drug may differ. Box 2 provides the generic and Canadian and American trade names for commonly used antipsychotic drugs.

Box 2

Trade Names of Antipsychotic Drugs Used in Canada and the United States

Generic Name	Canada	United States
clozapine	Clozaril	Clozaril
flupenthixol	Fluanxol	Fluanxol
haloperidol	Haldol	Haldol
chlorpromazine	Largactil	Thorazine
loxapine	Loxapac	Loxitane
thioridazine	Mellaril	Mellaril
fluphenazine	Modecate	Prolixin
pimozide	Orap	Orap
trifluoperazine	Stelazine	Stelazine
perphenazine	Trilafon	Trilafon

Doctors may choose to use one drug instead of another because they are familiar with it, or they have had good results with it. Sometimes a doctor selects a drug to avoid the side effects of another possible choice. For example, Haldol has a lower sedative effect than Largactil, but Haldol is more likely to cause restlessness than Largactil.

Many side effects occur only during the first few days or weeks of treatment. For example, cramped muscles may be a problem during the first week of treatment on Stelazine, but later this side effect may pass. For this reason and because it takes time and some experimentation to get the right dosage of a drug for each person, once a drug is chosen and the dosage is set, the doctor may hesitate to make changes. Instead of changing drugs, some side effects may be reduced by taking the drug at a different time of day. For example, if Largactil causes drowsiness which interferes with work, the doctor may ask the patient to take it at night so the sedative effect passes by morning.

Box 3 provides an overview of common side effects for the most frequently used

antipsychotic drugs. The drugs are listed on the right by their Canadian trade names. Along the top of Box 3 are four groups of side effects (Groups A through D). An explanation for each of these groups is provided at the bottom of the Box. Each drug is classified according to the likelihood that it will cause a side effect relative to other drugs used for the same disorder. The chances are described as high, medium, and low. For example, Clozaril has a high chance of causing drowsiness compared to Haldol, which, relative to other antipsychotic drugs, has a low chance of producing that effect.

Box 3

Side Effects of Some Antipsychotic Drugs

Drugs	Side effects			
Canadian trade names	Group A	Group B	Group C	Group D
Clozaril	high	high/medium	high/medium	very low
Fluanxol	medium	low	low	high
Haldol	low	low	low	high
Largactil	high	high	medium	low
Loxapac	medium	medium	medium	high
Mellaril	high	high	high	low
Modecate	medium	low	low	high
Orap	low	low	low	high
Stelazine	medium	low	low	high
Trilafon	low	low	low	high

Group A: Drowziness (sedation).
Group B: Hypotension. The person becomes dizzy, weak, or may even faint when standing up too quickly.
Group C: Anticholinergic effects, which include blurred vision, dry eyes, and dry mouth.
Group D: Extrapyramidal effects, which include rigid and cramped muscles (dystonia), tremors, mask-like face, stooped posture, partial or complete inability to move (akinesia), and restlessness (akathisia).

Designations of high, medium, and low indicate the chance that the side effect will occur relative to the other antipsychotic drugs. E.g., the chance of Orap causing Group C side effects is low compared to Mellaril.

ANTIPARKINSONIAN DRUGS

Some side effects of antipsychotic drugs can be controlled by using antiparkinsonian drugs. Parkinson's disease causes rapid tremors, mask-like facial expression, poor coordination, and exhaustion. Since these same symptoms often appear as side effects to antipsychotic drugs (see Group D in Box 3), doctors try to control them with antiparkinsonian drugs.

How do these drugs work? According to one explanation, the use of antipsychotic drugs causes an unwanted chemical imbalance in the nervous system. The anti-

parkinsonian drugs correct this imbalance and thereby reduce or eliminate the side effects of antipsychotic drugs. Generic names and Canadian and American trade names for commonly used antiparkinsonian drugs are listed in Box 4.

Box 4

Trade Names of Antiparkinsonian Drugs Used in Canada and the United States

Generic names	Canada	United States
trihexyphenidyl	Artane	Artane
diphenhydramine	Benadryl	Benadryl
benztropine	Cogentin	Cogentin
procyclidine	Kemadrin	Kemadrin

While these drugs may control some side effects of antipsychotic drugs, they too have side effects which may hinder learning. Drowsiness is a common side effect. These drugs may also cause blurred vision, dry eyes, and dry mouth.

Do the side effects of antipsychotic and antiparkinsonian drugs hinder learning?

All antipsychotic and antiparkinsonian drugs share important drawbacks. For some people they do not work. For others, the dose needed to have an effect is so great that suffering caused by the side effects outweighs the advantages of using the drugs.

Some side effects may be short or long-term. Short-term side effects are more common. For example, sedation, blurred vision, drooling, and tremors frequently pass shortly after treatment is underway. Tardive dyskinesia (TD) is an example of a long-term side effect. TD shows up as abnormal leg-jiggling, finger movements, and lip-smacking, among other reactions. It appears only after a person has been using an antipsychotic drug for some time. Once it begins, it tends to persist and treatment with the antipsychotic drug may have to be stopped.

The side effects of drugs may create learning problems. People treated for schizophrenic and paranoid disorders often perform more poorly on learning tests than people with the same disorder who are not being treated with medications. Why this happens is not really known. Indeed, not all mental health workers agree that drugs have a negative effect on learning. For instance, psychologists discovered that people who were good students before being treated for a disorder were helped in their studies by taking medications, but students who did poorly in the past were not affected one way or the other by the drugs.

The exact effects of medications on learning is a complicated subject. The difficulties a student is experiencing may be the result of drug side effects or a combination of factors in which the drugs are playing their part. For instance, going in

and out of a hospital may hinder learning ability. It is difficult to be motivated for learning when school attendance and the ability to study are constantly interrupted with hospital readmissions; indeed, re-hospitalization may have a far more dramatic adverse effect on learning and the quality of life than most side effects of drugs.

Box 5 lists the side effects of antipsychotic and antiparkinsonian drugs which are most likely to hinder learning. Chapter Five provides detailed descriptions of these problems and suggestions for reducing their negative effects.

Major Mood Disorders

The chief characteristic of mood disorders, also called affective disorders, is a noticeable and persistent disturbance of mood that markedly colours a person's view of the world. The most common are depressive and manic-depressive disorders, also called unipolar and bipolar disorder respectively. These disorders are treated with antidepressant drugs, electro-shock therapy, Lithium, and other antimanic drugs (e.g. Tegretol).

What are the major characteristics of depressive disorders?

A person treated for depressive disorder will report feeling hopeless, worthless, and excessively guilty. Low self-esteem accompanied by a preoccupation with failure may generate forgetfulness and a lack of interest in work and social activities. The person may have difficulties concentrating and making decisions. It is common to experience these feeling more intensely either in the morning or evening.

Energy is often low. Sleeping problems arise, including waking in the early morning hours. Physical problems emerge. Appetite and weight can increase or decrease. The person may feel restless, weak, and have thoughts of death and suicide. Indeed, suicide may be attempted. There are different levels of depressive disorders, ranging from major depression to mild but persistent depression.

What are the major characteristics of manic-depressive disorder?

Manic-depressive disorder is called bipolar disorder because the person swings between two poles: mania and depression. When manic the person feels excessively happy. Delusions may occur. Thoughts race quickly. Speech is often a nonstop rush, loud, rapid, and hard to understand. The person requires little sleep, is easily distracted, and may become obsessive or suddenly irritable. Plans are made and activities are begun without any sense of the time it may take to complete them. The person is likely to make poor judgements about health matters and blame others for her/his mistakes.

Box 5 How Side Effects of Antipsychotic and Anti-parkinsonian Drugs are Likely to Affect Learning

Group A: Drowsiness (Sedation).

These are common side effects which interfere with the ability to pay attention and concentrate. A student describes it as "thinking very slow, like it takes a great deal of energy to do anything. It's like being pretty drunk, but you're not." Sedation is often most pronounced when the person begins taking the drug. As the body adjusts to the drug, sedation may pass. Persistent drowsiness may be a sign of too high a dosage.

Group B: Hypotension and dizziness.

These are common side effects of antipsychotic drugs, but they are much less common with antiparkinsonian drugs. The person becomes dizzy, weak, or may even faint when standing up too quickly.

Group C: Anticholinergic effects, blurred vision, dry eyes, dry mouth.

This group of side effects is found with antipsychotic drugs and antiparkinsonian drugs.

Blurred vision: Near vision used for reading is more adversely affected than far vision.
Dry eyes: Eyes become sore and itchy. Eyeglasses and especially contact lenses may be difficult to use.
Dry mouth: It is difficult to swallow. A constant need for water may mean many interruptions during lessons.

Group D: Extrapyramidal effects, akinesia, restlessness, tremors, drooling.

These side effects are common with antipsychotic drugs and are controlled with antiparkinsonian drugs.

Akinesia: A zombie like effect, the person moves very slowly, is easily fatigued, and shows little facial expression. Speech may be monotonous. The person shows little interest in work, leisure activities, or social contacts. Akinesia may occur at any time and is commonly mistaken for social withdrawal and depression.
Restlessness (akathisia): The person is fidgety, constantly pacing or moving fingers, hands, and legs. Mild forms of restlessness include finding it difficult to sit still and remain on one task. This side effect is often confused with anxiety or part of a psychosis.
Tremors: These occur most often in the hands and jaw. With antipsychotic drugs the tremors are usually slow. Fine motor muscles in the hand may be affected. The drugs may also cause 'cogwheel rigidity', a stiffness which begins at the shoulders and spreads to other parts of the body.

Related side effects

Concentration and memory: In some cases confusion and impaired concentration are listed among the side effects of antipsychotic and antiparkinsonian drugs. Along with sedation and other side effects mentioned here, poor concentration interferes with a person's ability to pay attention and study or practice. Thus, antipsychotic and antiparkinsonian drugs create attention and rehearsal deficits, which in turn adversely affect memory. Verbal memory also seems to be hindered by antiparkinsonian drugs.

Tardive dyskenisia (TD): Tardive dyskenesia may occur after prolonged use of antipsychotic medications. TD appears as a long standing or permanent involuntary movement of the head, neck, and mouth. It may also affect legs and arms. Occasionally, the muscles that control breathing and swallowing are affected. The person may constantly grimace or smack her/his lips. TD may also cause deterioration of the brain centres involved with learning new material.

MOOD SWINGS

The big difference between manic-depressive and depressive disorders is mood swings, the change from mania to depression that occurs with a manic-depressive disorder. The mood swings may be mild or extreme. In most cases there is a period of normal behaviour in between. Each mood may last for many months or for as short a period as a few days. Some people swing repeatedly and often. Others experience only one or two swings during a lifetime. For some the mood swings are predictable.

How do these characteristics of mood disorders hinder learning?

As with most mental disorders, mental health workers are quick to point to the difficulty of determining which learning problems are related to the disorder itself, which are side effects of treatments, which are a combination of both, or which are consequences of social or economic problems. However, there is some agreement that depressive and manic-depressive disorders have their own effects on learning.

LOSS OF INTEREST

Reduced motivation affects performance on assessment tests, the desire to complete class work, and interest in work or leisure activities.

DIFFICULTY WITH SOCIAL SKILLS

Someone being treated for manic-depressive disorder is likely to have difficulty interacting with others and dealing with stressful situations.

POOR MEMORY

These people perform poorly on tasks which require close attention and practice to learn. Anyone who is easily distracted by feelings of hopelessness and guilt, as is the case during depression, or by racing thoughts during a manic period may be unable to pay close attention to her/his studies. Depression hinders the ability to remember. The problem may not be that the person is unable to retrieve information from her/his memory bank, but that the distractions kept the information from being stored in the first place.

WEAK PERFORMANCE SKILLS

Performance skills include the ability to do things that involve physical activity. Drawing pictures, assembling puzzles, and performing tasks like sawing wood and participating in sports are examples of performance skills. Individuals being treated for mood disorders may have difficulty learning things which relate to performance skills.

What treatments are used for depressive and manic-depressive disorders?

Common treatments for mood disorders are antidepressant drugs and

electroconvulsive therapy (ECT). The drugs Lithium and Tegretol are used to treat manic-depressive disorder during the acute phase of the disorder and to stabilize mood fluctuations.

ANTIDEPRESSANTS

Antidepressant drugs are used to treat depressive disorder and the depressive side of manic-depression. There are three groups of these drugs. One is the monoamine oxidase inhibitors, MAOIs for short. Another is tricyclic antidepressants (TCAs). The MAOIs are used less often than TCAs because people who use MAOIs must avoid certain foods. A third group called Newer Antidepressants are used frequently because they seem to have fewer side effects than either MAOIs or TCAs. Some antidepressants take several weeks before they become effective; however, Newer Antidepressants work more quickly.

The generic and trade names for antidepressants used in Canada and the United States are listed in Box 6.

Box 6

Trade Names of Drugs Used in the Treatment of Depressive and Manic-depressive Disorders in Canada and the United States

Generic Name	Canada	United States
Antidepressants for depressive disorders		
phenelzine*	Nardil	Nardil
amitriptyline**	Elavil	Elevil; Endep
amoxapine**	Asendin	Asendin
desipramine**	Pertofrane	Norpramin;Pertofrane
doxepin**	Sinequan	Adapin; Sinequan
imipramine **	Tofranil	Imavate; Janimine; Tofranil
Newer Antidepressants		
fluoxetine	Prozac	Prozac
fluvoxamine	Luvox	Luvox; Floxyfral
setraline	Zoloft	Zoloft
Antimanics for manic depressive disorder		
lithium carbonate	Carbolith; Duralith; etc.	Carbolith; Duralith; etc
valproic acid	Depakene	Depakane
carbamazepine	Mazepine, Tegretol	Epitol; Tegretol
clonazepam	Rivotril	Klonopin; Rivotril

* monoamine oxidase inhibitors (MAOIs)
** tricyclic antidepressants (TCA)

Which drug the doctor prescribes is often determined by her/his being familiar with one drug instead of another. Avoiding side effects is another factor. For instance, although MAOIs have fewer side effects than TCAs, the ones they do have can be quite serious. TCAs also have serious side effects, and they are not helpful for about 30% of the people who take them. As a result, much attention has been turned to Newer Antidepressants. Their side effects seem to be fewer than MAOIs and TCAs.

In some cases a side effect may be desirable. For example, a person being treated for depression may also have trouble sleeping. Since some TCAs are sedative, they may act as a sleeping pill as well as an antidepressant.

As in the case of antipsychotic medications, the side effects of antidepressants may occur during the first few days or weeks of treatment and then no longer be troublesome. Others can be long-term. When side effects are long-term and if the doctor does not change the drug treatment, the person may stop taking the medication without the doctor's permission. This is called non-compliance.

Box 7 lists antidepressants and their common side effects. Box 7 uses the same method of describing the side effects of these drugs as was used in Box 3 (page 7). For instance, the chance is high, relative to the other drugs listed, that Asendin will cause drowsiness.

Box 7

Side Effects of Some Antidepressant Drugs Used in the Treatment of Depressive and Manic-depressive Disorders

Drugs	Side effects							
Canadian trade names	Drowsiness	Dizziness	Confusion	Head-ache	Dry Mouth	Blurred Vision	Hand Tremor	Fatigue
Asendin	high	high	medium	med.	high	med.	med.	med.
Elavil	high	high	high	med.	high	high	high	high
Nardil	high	high	medium	med.	high	high	high	low
Pertofrane	medium	medium	--	low	high	med.	med.	med.
Sinequan	medium	high	low	low	high	high	med.	med.
Tofranil	high	high	medium	high	high	high	high	high
Prozac	high	high	high	high	med.	med.	high	--
Luvox*	high	--	--	high	high	--	--	--

Designations of high, medium, and low indicate the chance that the side effect will occur relative to the other antidepressant drugs. E.g., the chance of Prozac causing headaches is high compared to Sinequan and the chance of Elavil causing fatigue is high compared to Nardil.

*Information for Luvox is partial.

ELECTROCONVULSIVE THERAPY (ECT)

Compared to antidepressants, electric 'shock therapy', or electroconvulsive therapy (ECT), is used most often when drugs and psychotherapy are not effective or when someone is unable to take drugs. The depressive phase of manic-depressive disorder can also be treated with ECT.

After a patient has been anaesthetized, an electric shock is applied to one or both sides of the brain for about one second. Just as there are many ideas about how this shock is able to end depression, there is concern with how and when the treatment is used and the severity of its major side effect, loss of memory. This has led to much research on ECT and hospitals have developed rigid rules guiding its use.

LITHIUM

The most common drug treatment for manic-depressive disorder is Lithium. It is used to control mania, some depression, and mood swings. People being treated for schizophrenia who also show depressive characteristics may be treated with Lithium. For some, the results from using Lithium are dramatic if the drug is taken regularly. As a treatment for an acute phase of mania, the drug may take effect quickly. Long term use acts to prevent the recurrence of mania and so it must be taken every day, even when the person feels well.

Lithium is a troublesome drug. Because it has many side effects, patients are inclined to stop taking it. As well, the drug has a narrow margin of safety and therefore must be prescribed cautiously. Some side effects are impaired attention, irritability, anxiety, poor concentration, weight gain, and impaired memory. Lithium's side effects usually appear during the first weeks of treatment and may disappear after this initial period.

TEGRETOL AND OTHER ANTIMANIC DRUGS

Tegretol is actually an anticonvulsant which is used to treat epilepsy. In recent years it, along with other anticonvulsant drugs, has been used as an alternative to Lithium for treating manic-depressive disorder. Therefore, these drugs may also be called antimanic drugs. The most common side effect of Tegretol and all anticonvulsant drugs is sedation. Additional side effects may be a loss of physical coordination, dizziness, blurred and double vision, tremor, memory impairment, and confusion.

Which side effects of antidepressants, ECT, Lithium, and Tegretol hinder learning?

Mood disorders have their own effect on ability to learn. This makes it difficult to identify exactly how antidepressants, ECT, Lithium, and Tegretol hinder learning. In addition to trying to distinguish between the effects of the disorder and the side effects of drugs and ECT, many factors relating to these treatments must also be taken into account. For example, the amount of medication being taken and how long it has been used, how many electric shock treatments have been given and over what length of time, and the person's age all play a part in the effect these treatments may have on learning ability. In one study, Lithium did not hinder thinking skills, but in another, doctors reported damaged short-term and long-term memory.

The question about the side effects of ECT is particularly important to students and teachers. Put simply, does ECT destroy certain kinds of memory? The question is difficult to answer because depressive disorder seems to have its own negative ef-

fect on memory. It is certain that ECT causes the loss of some memory, but how much is lost and for how long is not clear. In one of many studies, people who got ECT did worse than a no-shock group on a memory test; however, six months later the differences between the two groups disappeared. In another study, ECT improved memory in the long-run, but the people's autobiographical and logical memory were poor for two weeks after the treatment.

Psychiatrists interviewed for this handbook agreed that ECT affects memory and suggested that teachers should be aware of the possible effects on memory. As for its long term effects, they noted that major changes have been made in the way ECT is done, which seems to reduce its negative effects on memory. However, the debate over ECT is by no means over. Listed in the Resource Guide are materials that present the arguments for and against the use of ECT in greater depth.

Thus, there is a great deal of disagreement about the exact effect of these treatments on learning ability. Box 8 lists the side effects which are quite likely to hinder learners. More detailed information about these effects and strategies to minimize the difficulties they create can be found in Chapter Five.

Anxiety Disorders

What are the major characteristics of anxiety disorders?

Anxiety is a vague, unpleasant dread or fear of some thing. The person feels distressed and uneasy. All anxiety does not constitute a mental disorder; in fact, it is a normal reaction to fear. But when it appears for no obvious reason or in response to something which is not so dreadful, it may be treated as an anxiety disorder. Thus, anxiety disorders are over-reactions to distress or fear.

The person is said to have an anxiety 'attack'. An anxiety attack may be mild or terrifying. It can occur suddenly or be an on-going distress. Anxiety attacks become a mental disorder when they are so intense that the person feels unable to engage in everyday activities.

The physical reactions to anxiety include a pounding heart, a stomach 'tied-up-in-knots', tense muscles, cold and sweaty hands and feet, a dry mouth, and intense breathing. The person may begin to tremble. Other signs are restlessness, pacing, and nail biting. The body's reaction will vary depending on the amount of anxiety experienced. Anxiety also affects one's thoughts. The person may have vague worries or intense thoughts of death. Fear of suffocation or dying in one's sleep are common.

Anxiety may be focused or free-floating. Phobias are focused anxiety. Examples are extreme fear of closed spaces (claustrophobia) and social situations (social phobia). A free-floating anxiety attack is described as a vague, nebulous feeling. No one specific thing triggers the feelings. An example is panic disorder. Three types of anxiety disorders are most likely to interfere with learning: social phobia, agoraphobia, and panic disorder.

Box 8

How Side Effects of Antidepressants, ECT, Lithium, Tegretol, and other Anticonvulsants (Antimanic) Drugs are likely to Affect Learning

Drowsiness (sedation)

Antidepressants, Lithium, Tegretol, and other anticonvulsants cause drowsiness. A student is quite likely to fall asleep during class or other activity. It is often more pronounced during the first few weeks after beginning to take the drug. Drowsiness interferes with concentration and the ability to pay attention and is an important side effect which affects learning.

Anticholinergic effects

This includes the following:

Dry mouth: A common side effect which creates the need for constant breaks to get a drink of water.
Blurred vision: Antidepressants may blur near vision, which affects reading and writing.
Hand motor speed and tremor: Sometimes antidepressants and Lithium will cause fine, rapid movements of the hands and fingers often accompanied by sweating. Lithium may cause slow hand motor speed.

Concentration, confusion, and memory loss

Problems with concentration caused by Lithium are bothersome enough to make people stop taking the drug against a doctor's advice. Confusion is also reported with Lithium and several antidepressants. Confusion with Lithium may be serious since it can be a sign of an overdose, which may lead to clouding, delirium, coma, and even death. Along with most of the side effects mentioned here, poor concentration interferes with a person's ability to pay attention and study or practice. Thus, antidepressants and Lithium may create attention and rehearsal deficits which adversely affect memory. ECT also has an adverse effect on recent memory, autobiographical memory, and verbal memory. Lithium may hinder the ability to retrieve old memory and therefore students may need more practice to learn. (See Chapter Three for a detailed discussion of memory.)

Fatigue

Several antidepressants may cause fatigue, a feeling of weariness or tiredness as if a person has done a great deal of work or has been through an intense emotional experience. It becomes difficult to complete any task.

Mania

When antidepressants are used with someone being treated for manic-depression, the drugs can bring on mania.

SOCIAL PHOBIA AND AGORAPHOBIA

A phobia disorder is an intense, focused fear which is very much out of proportion to any real danger. To avoid whatever is feared, the person may do almost anything. Social phobia is a fear of being in social situations where others may pass judgements on how you look and act. The person will do whatever is necessary to avoid speaking in front of people and going to public events, including parties and school. Agoraphobia is a severe fear of open, public places. Agora means a market place, and so agoraphobia refers to a fear of being left alone (abandoned) in public places, like markets and shopping centres.

PANIC DISORDER

A panic disorder is a type of anxiety disorder characterized by repeated and usually unpredictable panic attacks. Imagine that you leave the house to go shopping. Just as you start to get on the bus you suddenly feel an intense sense of doom, then raw fear. Your hands begin to shake and your legs will not move. You feel that you cannot breathe. This is a panic attack. These attacks may involve sweating, shortness of breath, a sense of choking, faintness, nausea, a general feeling of having lost touch with reality, and hot and cold flashes. Usually panic attacks last for a short time, but the fear that one may occur at any moment creates severe anxiety. This is called anticipatory anxiety.

People suffering from anxiety disorder usually look for a cause. Having found one which they think is the source of their fears, they avoid it. If the anxiety is focused (i.e. a phobia), this strategy may work. But if the anxiety is free floating, it will not and the person is likely to start avoiding more and more situations in a futile attempt to avoid attacks. The person's lifestyle becomes increasingly limited. This may create serious problems for the person's family and friends. People who experience these forms of anxiety disorder may have a great deal of trouble going into a classroom and participating in the social activities which are often a part of most adult education programs. A psychiatrist provided this illustration of how a person who is experiencing an anxiety attack may behave in a social setting like a classroom.

> *"You might notice that the person moves into the corner and becomes withdrawn. Shortness of breath is common so you may notice panting. If you approach the person you may see sweating and tremor. If the person suffers panic attacks or social phobia, it's quite likely that you'll see an attack. It's also quite likely that once the student leaves, he won't return."*

What treatments are used for anxiety disorders?

Psychotherapy is a form of treatment for anxiety disorders. For instance, people with social phobia and agoraphobia may participate in psychodramas which allow them to act out their fears. Voluntary behaviour therapies are used to train a person to enter public settings without developing anxiety. Life skill programs are used to practice being in social situations.

A common treatment is the use of antianxiety drugs and some antidepressants. Generic and trade names of antianxiety drugs used in Canada and the United States are listed in Box 9.

Do the side effects of antianxiety drugs hinder learning?

Because antianxiety drugs act as sedatives, the person may become drowsy. Drowsiness in turn decreases concentration and attention. It may also hinder coordination. This side effect may pass shortly after the person begins using the medication; however, it can present a serious problem for learners. Chapter Five has a detailed description of the adverse effect of drowsiness on learning and strategies to reduce the problem.

Box 9

Trade Names of Antianxiety Drugs Used in Canada and the United States

Generic Name	Canada	United States
lorazepam	Ativan	Ativan
buspirone	Buspar	Buspar
chlordiazepoxide	Librium	Librium
diazepam	Valium	Valium
propranolol	Inderal	Inderal
alprazolam	Xanax	Xanax

Substance Abuse Disorders

What are the major characteristics of substance abuse disorders, and which substance abuses are likely to hinder learning?

Substance abuse refers to a social or work related problem directly related to the regular use of some substance. Substance abuse also triggers other mental disorders. To be diagnosed as having a substance abuse disorder, the person must be dependent on its use; that is, the person cannot control her/his use of the substance. In addition, the person needs progressively more of the substance to experience the same effect, and if the person can no longer get the substance, some form of withdrawal (e.g. a flu-like experience) occurs.

When instructors and psychiatrists were asked which substance abuse disorders should be included in this handbook, alcoholism and inhalant abuse (especially glue) were suggested.

ALCOHOLIC SUBSTANCE ABUSE

Common characteristics of alcoholic intoxication are slurred speech, lack of coordination, and unstable moods. Abuse usually occurs in one of three different patterns: daily intoxication, drunkiness at specific times (e.g. on weekends), and long periods without drinking which are followed by binges of heavy drinking, which may last for some time. As alcoholic abuse continues, the characteristics of withdrawal become more severe. Added to the typical headache and stomach pains are muscle tremors, high blood pressure, and anxiety.

A more serious condition which results from alcohol abuse is delirium tremens (DTs), an acute brain disorder which causes fever, tremors, delusions, disorientation, and hallucinations. Long term abuse may also lead to dementia. Dementia is a loss of memory, an inability to think abstractly, impaired memory, poor judgement, and difficulty following even simple directions.

In severe cases, alcoholic abuse leads to conditions called Wernicke's Syndrome and Korsakoff's Syndrome. Wernicke's Syndrome involves poor coordination, im-

paired thinking, and irregular eye movements. Korsakoff's Syndrome is an irreversible loss of specific memories and learning abilities. These two syndromes may occur together.

The effects of alcohol abuse on learning are obvious from this description. What is not obvious is the tendency to deny that a problem exists. For this reason, a psychiatrist was asked to describe what is likely to occur when a teacher suspects alcohol abuse is influencing a student's performance.

> *"Denial is what we see most often. You must be very straight forward: 'It appears to me that you have been drinking. Your behaviour is making it very difficult for me to be helpful. Are you receiving any help for this problem?' If the person says no or denies it, you must be firm about what you are prepared to do. Nothing is gained by letting the person drag you into his or her difficulties."*

> *"Can you offer specific advice?"*

> *"Yes. You must be firm. Make it clear that you detect a problem and suggest that the person go for treatment. For example, you might provide the address of an alcohol treatment program or AA. In any case, you must make it very clear that you can't continue teaching unless the problem is being treated."*

INHALANTS

Inhalants are chemicals which produce fumes. By breathing in these fumes the individual experiences a 'high' or 'rush'. Common inhalants are solvents, gasoline, glue, cleaning fluid, hair spray, and cookware coating.

Inhalants are used by adolescents and the poor because they are readily available at a low cost. Low doses of inhalants create a sense of stimulation. High doses can cause loss of consciousness. Sniffing high concentrates of inhalants may produce heart failure and death. Long term abuse of inhalants causes physical damage, including damage to the central nervous system. Sniffing inhalants can lead to the development of behaviours which are like psychotic disorders. A common effect is brain damage leading to dementia. Dementia involves the loss of intellectual abilities, including problems with memory, judgement, speech, and decision making.

How are substance abuse disorders treated, and will these treatments hinder learning?

Not using these substances is the first and most important aim of treatment. Except for the use of a drug called Antabuse, which causes a person to have violent physical reactions whenever alcohol is consumed, various forms of psychotherapy and Alcoholic Anonymous and Narcotics Anonymous are the primary forms of treatment. These treatments are unlikely to create problems for a person who wishes to

participate in an adult education program, although it may be necessary to change class time to accommodate the treatment program. If substance abuse leads to other disorders, drugs may be used. For instance, antipsychotic medication may be involved if the substance abuse created a psychotic disorder.

Brain Injury Disorders

What are the major characteristics of brain injury disorders?

The brain, the spinal cord, and a group of related nerves are called the Central Nervous System (CNS). Brain injury usually involves damage to the CNS. Strokes, some diseases (e.g. Alzheimer's disease), and accidents are common causes of injury to the CNS. Damage to parts of the brain and behaviours which accompany this damage are brain injury disorders. These disorders are increasingly a problem because advances in medical treatment are saving the lives of people who in the past would have died. Brain injury creates severe emotional and learning problems.

The brain is divided into specific regions (See Box 10). Each of these regions of the brain controls certain mental and physical activities. For example, the frontal lobes, located at the front of the brain, integrate incoming information from other regions of the brain. When you see a tree and draw a picture of it, the frontal lobes are bringing together the image of the tree with the muscle activity of your hand. If the frontal lobes were injured, you may see the tree but be unable to draw it. People with frontal lobe injury also find it difficult to stop one activity and begin another. This is called perseveration. Damage to the temporal lobes, located just behind and to the side of the frontal lobes, causes memory and speech impairments. Thus, damage to one or more regions of the brain or other parts of the CNS cause specific problems. Very often these problems hinder related activities, and the emotional stress which accompanies the difficulties creates more trouble.

How can brain injury adversely affect learning ability?

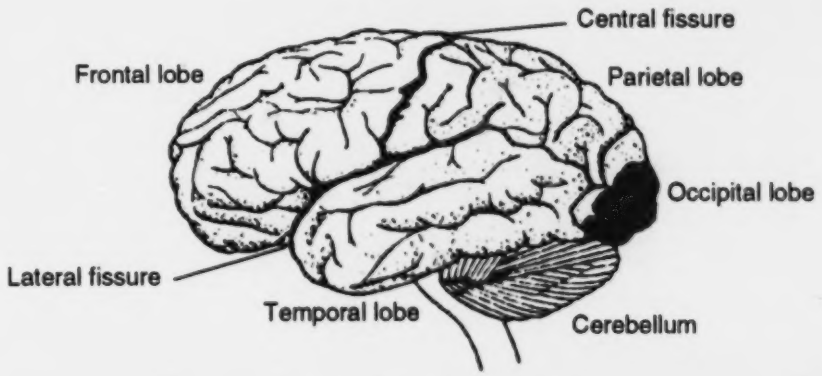
People whose injuries do not cause a visible physical disability can be confusing to instructors because these people may appear to have no difficulties, while in fact a brain injury is creating problems with planning, organization, memory, and choosing appropriate problem solving strategies. Irritability, depression, lack of confidence, and the following difficulties are associated with brain injury disorder.

UNREALISTIC EXPECTATIONS

Perhaps the greatest difficulty for adults suffering from head injury disorders is the struggle to develop realistic expectations for themselves. These people want to

Box 10

Diagram of the brain with the various lobes (sections) labelled.



return to their previous lifestyles, but this cannot be done. They find that they can not work at the job they once had or relate to friends and families as they did before they were injured. Usually the adult refuses to accept the situation. Meanwhile, former employers, friends, and family become increasingly frustrated. Adult educators working with brain injury victims in a hospital report very high divorce rates among their students as one indication of the frustrations and suffering which these adults face.

ATTENTION DEFICITS

Attention deficits are described as 'the hallmark of traumatic brain injury' (Good Samaritan Community Healthcare, 1987). Attention deficits typically involve excessive physical activity which distracts attention and thereby interferes with learning. (It is called hyperactivity in children.) Problems with sustained attention create a 'waxing and waning effect', which cause gaps in what a student perceives. Without sustained attention, information is lost and the student is confused. As attention wanders, the student's handwriting becomes inconsistent. Writing is disorganized and filled with errors. Reading comprehension suffers because the student has 'missed' bits and pieces of information as she/he reads a story. Furthermore, deficits in selective attention interfere with the ability to concentrate on a specific task. Any noise or visual distraction will capture the person's attention, making concentration extremely difficult.

POOR MEMORY

Memory deficits are related to attention problems. If attention is lacking, information is not stored in the person's memory in the first place (See Chapter Three). However, even if the person is able to pay attention, the brain injury may have impaired the ability to store information for even a very brief period of time. Therefore, the person will lack the ability to learn new information.

REDUCED STAMINA

The extra effort needed to perform each task and the emotional stress which accompanies these difficulties cause fatigue. Fatigue contributes to attention problems. This results in further failure, and the cycle of frustration, low-self-esteem, and learning deficits continues. Often, students are better able to learn early in the day or after a nap when they are well rested.

What are the common treatments for brain injury disorder?

The increase in the number of people affected by brain injury has led to improved treatment. Rehabilitation programs include psychotherapy, biofeedback methods, special educational programs, and the use of computers and other devices to help in retraining functions. Medications are also used, the most common being anticonvulsant drugs, which reduce the physical tremors and loss of motor coordination which may accompany brain injury. The generic and trade names for the most frequently used anticonvulsants are listed in Box 11.

Box 11

Trade Names of Anticonvulsant (and Antimanic) Drugs Used In Canada and the United States

Generic Name	Canada	United States
valproic acid	Depakene	Depakane
carbamazepine	Tegretol	Epitol
clonazepam	Rivotril	Klonopin; Rivotril

What are the side effects of these treatments, and how might they hinder learning?

Anticonvulsant drugs can cause confusion, reduced initiative, irritability, depression, and a decrease in the person's ability to organize and carry out problem solving activities. Blurred vision, dry eyes, and a dry mouth are other side effects which may interfere with learning ability. These side effects usually last only a short time. Often they can be reduced or eliminated by reducing the dosage or by using another medication.

More On Mental Disorders and Medications

A few specific questions about mental disorders and medications that adult educators asked are considered below.

What are anorexia nervosa and bulimia?

Anorexia nervosa is an eating disorder. The person, usually a woman, has an intense fear of becoming overweight. The person 'feels fat' and refuses to eat for fear of gaining weight. Most women are under 30 years of age and from middle and upper-class families. The disorder is difficult to treat and can lead to death. Recovery can be spontaneous.

Bulimia is also an eating disorder, but in this case the woman goes on eating binges of rich foods which is followed by self-induced vomiting. Bulimia is frequently associated with depression. Treatment includes various forms of psychotherapy and in some cases antidepressants.

What effect does age have on the side effects of drugs?

Drug dosage and drug side effects can differ according to the age of the person being treated. Generally speaking, children under 12 and persons over 65 will react differently to drugs than adults between these ages. For example, among the elderly the danger of heart problems and tremors may create more serious problems than for children or younger adults. Also, elderly people may be taking other drugs which interfere with medications used to treat mental disorders. The side effects of drugs described in this section are for people between the ages of 16 and 65.

How does a person's health and lifestyle affect drug treatment?

Physical conditions like pregnancy, kidney and liver disease, and heart disease make a difference. Body weight and lifestyle also make a difference. If people are overweight or if their health is poor due to substance abuse, some medications are more likely to cause serious side effects than others.

Does drinking alcohol or coffee, smoking, or taking street drugs create additional problems?

Cigarette smokers may need greater doses of certain drugs to achieve the same effect as someone who does not smoke or is not constantly around cigarette smokers. Caffeine in coffee works against the effects of some medications. Some drugs are affected by alcohol and street drugs. Alcohol with antipsychotics and antidepressants increases sedation and results in poor concentration. Alcohol and Lithium should never be combined. Precise information about the reaction of street drugs with medications taken for mental disorders is not available.

What is a personality disorder?

This term covers a wide range of disorders. The characteristics of these disorders

are often less severe than psychotic and mood disorders. One example is the antisocial disorder in which a person repeatedly gets into trouble in social settings. The person seems to show little or no concern for others, is easily frustrated, and quick to blame others. Perhaps the greatest difficulty for learning created by personality disorders is a poor ability to learn from mistakes.The most common treatments for personality disorders are various forms of psychotherapy or behaviour modification (See Chapter Two), although in some cases medications are used.

What is a 'drug holiday'?

This is a period of time during which drug treatment is stopped. A psychiatrist may use a drug holiday to provide a rest from the side effects of a medication.

Why do people just stop taking their medications without speaking to their doctor?

When a person stops taking her/his medications without the doctor's approval, it is called non-compliance. It occurs for two related reasons. First, when people no longer experience the characteristics of the disorder, they are no longer motivated to take the medications. Second, if the medications cause unpleasant side effects, people may quit taking the drug. This is likely to happen when they no longer experience the effects of the mental disorder.

What happens to a person who stops taking medications without notifying her/his doctor?

Most drugs take from one to several weeks to have an effect; so suddenly stopping may not be immediately noticeable. With some drugs (e.g. antipsychotics), the first effect may be very positive since unpleasant side effects may disappear. However, soon a characteristic of the mental disorder may return and the person 'gets sick.'

It is common for people being treated for schizophrenia to be readmitted to a hospital because an acute phase of the disorder followed a period of drug withdrawal without a doctor's advice. The effects of suddenly not taking antidepressants may include some physical aches and pains, headaches, sleep disturbance, and a return to the characteristics of depression (e.g. moodiness). A sudden withdrawal from Lithium may cause anxiety, irritability, changing moods, and in some cases it triggers a psychotic reaction. However, there are cases where abrupt withdrawals from antidepressants and Lithium caused no unpleasant reactions.

Persons being treated for mental disorders under a court order violate the conditions for living in the community when they stop taking medications without a doctor's advice. If this occurs and the student's instructor knows about it, the instructor should refuse to keep this information confidential. Refer to the discussion on Confidentiality (page 73) for suggestions about what you should do if this problem arises.

What is the difference between mental disorder, mental illness, and insanity?

These terms suggest a different approach to the causes of emotional and behavioral problems. Mental disorder is the most neutral term because it does not assume that problems are caused by disease. Mental illness refers to the same emotional problems as mental disorder, but it suggests that the cause is some disease, much the same as a physical illness. Since there are good reasons to question this, we have chosen to use the term mental disorder. Insanity is a popular term for mental disorder. It has a legal meaning. Legally, persons are insane when they are not responsible for their criminal actions. Except for its legal use, the term is derogatory.

Chapter Two

THE MENTAL HEALTH SYSTEM

TO work effectively with people being treated for mental disorders, instructors and literacy coordinators need to be familiar with the mental health system. This chapter focuses on the following topics.

- Types of treatment services
- Mental health workers and their responsibilities
- Types of treatments
- Patients' status: the voluntary and involuntary patient
- Patients' rights
- Treatment issues

Types of Psychiatric Treatment Services

There are four types of psychiatric services. These are mental hospitals, psychiatric units in general hospitals, walk-in clinics, and psychiatrists' offices. Family doctors also treat individuals for mental disorders. Since visiting a doctor's office is familiar to most of us, the focus here is on services provided in hospitals and clinics.

The variety and extent of services available to people differs considerably depending on location. For instance Edmonton, Alberta has a wide range of psychiatric facilities, including a major mental hospital. Toronto, Ontario is another centre where one finds several mental hospitals, community walk-in clinics, and self-help groups. Smaller communities and rural areas may have few services or in some cases none at all. In these areas people are sent to other places for treatment.

The model for many of the examples used in this chapter are the services available in Edmonton, Alberta where Highwood School, the sponsor for producing this handbook, is located.

Mental hospitals

Mental hospitals treat in-patients, people admitted for short-term and long-term treatment. Most mental hospitals treat people for severe forms of mental disorder (e.g. psychotic disorders). The length of stay depends on the severity of the disorder; however, it may be influenced by other factors. For example, if the hospital is in an area with community support services, only those needing constant or specialized treatment will be admitted to the hospital. Where there are good community resources, fewer people are admitted and those who are admitted have shorter stays.

Mental hospitals are divided into wards or services. When a person is first admitted she/he usually goes to the admission or assessment service. The person will remain there until she/he is discharged or placed in another service. Anyone needing constant supervision (e.g. someone who has attempted suicide) will be placed in an Intensive Care Unit (ICU). People over 65 will be admitted to a psycho-geriatrics service, if one is available. Long-term patients may be placed in chronic care wards and rehabilitation services.

Mental hospitals and prisons

In Canada, if a person is sent to prison for more than two years she/he goes to a federal penitentiary. A sentence shorter than two years is served in a provincial prison. Federal prisoners requiring psychiatric treatment are sent to Regional Psychiatric Centres (RPC's) operated by the Correctional Services of Canada. For example, prisoners in British Columbia are sent to the RPC at Abbottsford, B.C., and those on the prairies go to the RPC at Saskatoon, Saskatchewan. Prisoners in provincial prisons are treated in special units within the prison, sometimes called Assessment and Treatment Units (ATUs). Prisoners in both federal and provincial prisons may be transferred to a forensic service in a local mental hospital if forensic service is available. Forensic psychiatry is a branch of psychiatry which deals with legal questions. For example, a forensic psychiatrist may be asked by a court to assess a person's mental condition when she/he allegedly committed the crime. A forensic service is a high security unit in a mental hospital where this kind of assessment is done. It is also a place where people who have been convicted of committing crimes are held for treatment. Forensic services exist in locations with comprehensive services, like Edmonton, Alberta.

General hospital psychiatric service

General hospitals may have emergency psychiatric services and short-term treatment services. Small, rural general hospitals may deal with emergencies and then refer people to hospitals in larger centres or to their family doctor for further treatment. Large urban and regional general hospitals will have emergency care and specialized units for full treatment. Just how much help the general hospital provides depends upon the size of the hospital, the nature of the community it serves, and the

number of beds set aside for psychiatric care.

Small hospitals usually rely on family doctors but may have mental health workers for emergency service. The larger the hospital the more likely it is that psychiatrists will be on the staff along with other trained mental health workers. A good service includes some form of assessment, emergency treatment, and links to community programs.

Walk-in and out-patient clinics

In some places, large general hospitals and mental hospitals offer 'walk-in' clinics, also called out-patient and partial-patient services. In general hospitals these clinics may be part of the emergency treatment service. Many mental health 'walk-in' clinics operate independent of hospitals.

These clinics offer day treatment, evening programs, and weekend programs. They allow people to live at home and come to the service for treatment. This makes it possible to shorten hospital stays, maximize normal living patterns, minimize the social stigma of mental disorder, and increase opportunities to use community resources (e.g. adult education programs).

Ideally, these clinics also provide a bridging function. That is, during the stressful period that follows discharge from a hospital and release into the community, an individual can move back and forth between the community and 'walk-in' clinic until she/he adjusts to living outside the hospital. As the person creates a support network in the community, she/he is able to move further away from hospital treatment and rely on community services. This helps patients avoid relapses.

SPECIAL CLINICS

One type of walk-in service is the special clinic where people go for a particular treatment. They may operate like satellite community-based programs of a mental hospital or be located in a general hospital. The special clinic may treat specific disorders like schizophrenia, depression, or substance abuse. In addition to going to the clinic for medications, the person may attend therapy groups at the clinic, turn to it during a crisis, and use it as a drop-in centre. Some clinics operate residence programs. In rural settings, a regional mental health facility often provides access to psychiatric counselling.

Mental Health Workers

Mental health workers include medical doctors, nurses, psychologists, pharmacists, social workers, and occupational and recreational therapists.

Medical doctors

Medical doctors are licensed to practice medicine. All medical doctors, including a family doctor, can prescribe drugs to treat mental disorders. In hospitals and community-based programs, medical doctors are responsible for all medical treatment.

CLINICAL DIRECTORS

A clinical director is a medical doctor in charge of treatment in a clinic or mental hospital. The director is responsible for all treatment policies and practices in the hospital and satellite community-based programs. The director may also treat patients.

SERVICE DIRECTORS

Large hospitals are usually divided into different services or units. Each service may have a physician who is the service director. The director coordinates treatment in the service by supervising the work of other mental health workers. The director is responsible for the overall operation of the programs and patient care in the service. The service director usually treats patients.

PSYCHIATRISTS

A psychiatrist is a licensed doctor who specializes in the diagnosis and treatment of mental disorders. She/he is the person who is responsible for the patient's care. The psychiatrist is able to prescribe and change a person's medications. Some work full-time in hospitals; others may have private practices, but most combine the two. In the majority of hospitals and clinics each patient is assigned to one psychiatrist. A psychiatrist, being a physician, can also treat patients' physical disorders.

Nurses

In the recent past many nurses were Registered Psychiatric Nurses after having completed specialized courses in nursing and psychiatric care. Today, the Registered Nurse program is being phased out and instead nurses obtain a university degree in nursing. Nurses work with other mental health staff in developing and providing therapeutic care. Much of their time is spent in direct patient care. This includes planning, managing, and supervising social and recreational activities, assisting patients with daily living activities, participating in individual and group counselling, administering drugs, and attending to patients' physical needs.

CHARGE NURSES

Each ward or service in a hospital has a charge nurse who supervises other nurses and who is responsible to the service director for proper nursing care. Charge nurses organize nursing schedules and plan, manage, and evaluate the programs taking place on their wards.

COMMUNITY NURSES

Community mental health nurses specialize in community networking. They assist out-patients living in the community by helping them gain access to community resources and adjust to specific problems which arise out of daily living. They may monitor medication needs and drug side effects. Community nurses provide counselling and crisis intervention services.

Psychologists

Psychologists work in hospitals, clinics, and community programs. While they may be called doctors because they have a doctoral degree in psychology, they are not medical doctors and so they cannot prescribe drugs or treat physical health problems using medical methods. Psychologists perform many services. They assess mental disorders, recommend treatments, and supervise a variety of individual and group therapies, especially behavioral programs. They administer tests which measure mental ability and emotional stability. They evaluate the test results and use these results to recommend treatment.

Social workers

Social workers have a university degree in social work. Among other duties, they prepare a case history for each patient. This is a report of a person's background based on the social worker's interviews with the patient, the patient's family and friends, employers of the patient, etc. The histories are used to identify social factors which may be contributing to a patient's mental disorder. For instance, a social worker may learn that a person is the victim of incest. Social workers also supervise individual and group therapy programs. In the community they develop and support links between community activities and hospital treatment. They help clients gain access to resources, assist them in financial planning, provide crisis intervention, counselling, and hospital discharge planning.

Occupational therapists (O.T.'s)

Occupational therapists assess a patient's physical, emotional, and social skills and her/his ability to care for herself/himself, to work, and to participate in leisure activities. They supervise programs which train people in vocational, recreational, and interpersonal skills. They counsel individuals about job opportunities and supervise work programs in hospitals and in the community.

Recreational therapists

A recreational therapist is trained to assess the patient's physical and emotional skills necessary to participate in physical, recreational, and leisure activities. In addi-

tion to assessing ability, they plan and supervise recreational activities in hospital and community programs.

Other mental health workers

Other mental health personnel found in hospitals or community-based clinics include pharmacists, physiotherapists, medical technologists, art and music therapists, chaplains, and support staff. In some hospitals (but more often in community-based programs), legal-aid advisers and patient's advocates are available.

Common Treatment Therapies

A person will usually participate in different types of therapies. While she/he is taking medication as one therapy, she/he may be attending a therapy group one evening each week. Students being treated for mental disorders are likely to refer to these therapies in the normal course of conversation because therapies are an important part of their daily lives. An example of this is provided by this student's comments.

> *"When I leave here I'll go to O.T. I like that because it gives me a chance to work with my hands and talk with the fellows. It's more like the real thing than groups. I have Rec. in the morning. I don't mind that. Then I go to reality therapy and twice a week to anger group."*

For hospitalized students, attending therapy groups may consume several hours of their day. Someone who must attend a group at a hospital or community clinic while living in the community may have to plan other activities around the group's scheduled meeting time. Teachers will improve their ability to communicate with their students by being familiar with their students' therapies.

Physical therapy

Physical therapies used to treat mental disorders include both drug treatments and electric shock therapy. Formerly surgery was used as a physical therapy, but it is almost never used now.

DRUG THERAPY

This therapy (also called chemotherapy) uses chemicals to treat mental disorder. It is the most common therapy used in the treatment of anxiety, mood disorders, psychoses, and some childhood disorders. Drug therapy usually does not cure a mental disorder but it controls symptoms of the disorder. Individuals may adminis-

ter their drugs themselves, just as people take prescription drugs for physical diseases, or the drugs may be administered by a nurse. Drugs can cause side effects, which can be minor and last only a short while after the drug is first taken, or they can cause serious physical and psychological problems lasting as long as the drug is used. Chapter One provides a description of the drugs commonly used to control major mental disorders, their side effects, and their impact on learning.

ELECTRIC SHOCK THERAPY

Electric shock therapy (also called electroconvulsive therapy or ECT) is used much less frequently than drug therapy. It is most commonly used to treat major depressive disorders. An electric current is passed through one or both sides of the brain for about one second while the patient is under general anaesthetic. ECT is a controversial treatment in part because of its side effects. ECT may destroy certain kinds of memory, a particularly important concern to teachers. ECT's side effects and its influence on learning are described in Chapter One.

Psychological therapies

Psychological therapies are also called 'talking cures'. In these therapies the person being treated works with a therapist either individually or in a group. There are many types of psychological therapy. One textbook lists thirty-two types. The Resource Guide contains a list of materials which provide more complete information on the wide variety of psychological therapies. Here we describe those most often used in hospitals and community treatment programs.

BEHAVIOUR THERAPY

Behaviour therapy is actually a group of therapies each of which focuses on learning as the method to change behaviour. Those who use this type of therapy believe that all behaviour - both normal and abnormal - is learned. People continue to behave a certain way because that behaviour is somehow rewarded. This type of therapy is also called behaviour modification. A well known behaviour therapy is the token economy program.

Token economy is used most often in hospital wards for chronic (i.e. long-term) inpatients. It teaches behaviours which the staff believe are socially acceptable and helpful to the patients. Examples of behaviours taught include getting up in the morning, going to work, and following ward rules without resistance. Performing an approved task is rewarded with tokens. Behaviours described as 'inappropriate' may be punished by charging the patient a certain number of tokens. Tokens are exchanged for rewards. For example, attending school may earn 10 tokens. Watching television on the ward may cost 5 tokens. The person exchanges 5 earned tokens for the reward of watching television, and 5 tokens are saved to purchase other rewards. Token economy therapy is successful in teaching basic social skills, such as taking a daily bath. It is used successfully when a person has low or impaired mental abilities. It is less effective when it is used with normally functioning adults and for teaching complex behaviours.

FAMILY AND MARITAL THERAPY

A therapist works with partners and families of an individual with a mental disorder in order to reduce problems within the family and to help family members cope with the disorder. In a typical situation the therapist helps a couple to change behaviours which hinder their ability to care for each other and interact effectively. Family violence, for example, may be treated with family therapy.

GROUP THERAPY

Several kinds of therapy are called group therapy. This means that one or more therapists work with a group of individuals who are being treated for the same or similar disorders. Group therapy is used to help people manage their anger, avoid substance abuse, develop assertiveness, or manage depression. The emphasis is on members of the group being guided by therapists, who encourage the group members to help each other resolve common problems. One advantage to group therapy is that group members discover that other people share their problems and that they are not alone. Groups are supportive and promote self-esteem.

INSIGHT THERAPY

This therapy, also called psychoanalysis, uses techniques developed by psychoanalysts to help a person explore deeply hidden feelings causing mental disorder. One technique, for example, is free association. Most people will resist thinking about past events which are painful. The therapist assists the person in overcoming this resistance by encouraging her/him to say whatever comes to mind. Then the therapist helps the person to associate whatever was said with hidden feelings and conflicts. Doing this may uncover the cause of disorders. Insight therapy is usually an individual therapy, although it can be used with groups.

REALITY THERAPY

Reality therapy is either a group or individual therapy used to teach people to make decisions, to recognize the likely consequences of their decisions, and to accept responsibility for their actions. Since the inability to make decisions and accept responsibility are characteristics of several mental disorders, reality therapy is used in the treatment of a variety of disorders.

THERAPEUTIC COMMUNITY

The therapeutic community is used in hospitals and other institutional settings. A group of individuals sharing similar problems live on a ward. During the day several group therapy sessions take place, each of which focuses on a particular behaviour problem (e.g. anger). Outside these groups, the patients (called residents) and therapists interact. Along with the group sessions, this ongoing interaction is supposed to help residents learn to live with others in ways that the staff consider to be socially acceptable. In some therapeutic community programs, staff and residents make collective decisions about all aspects of the program; in most cases staff directly or indirectly make major decisions.

Patients' Status: The Voluntary and Involuntary Patient

At first glance the difference between a voluntary and an involuntary patient seems obvious. A voluntary patient is someone who freely chooses to be admitted to a hospital for care. An involuntary patient is someone confined to a mental hospital against her/his will. Involuntary patients are committed. In Alberta, for instance, this happens when the person is believed to have a mental disorder, the disorder can only be treated in a hospital, and the person appears to be dangerous either to herself/himself or others.

The person's willingness to be treated can be ambiguous and she/he may be subject to coercion. An individual may be told that unless she/he volunteers, doctors will have her/him committed. People who enter a mental hospital as voluntary patients may agree to treatment they do not really want because they are afraid that their status will be changed to involuntary by a commitment order.

There are several ways to make someone an involuntary patient. Boxes 12 and 13 describe common ways.

Patients' Rights

While the Canadian Charter of Rights and Freedoms is having an impact on patients' rights, the most important laws are found in the Mental Health Act of each province. It is not possible to discuss these rights in each province. Government brochures and publications by self-help groups which describe these rights are listed in the Resource Guide. This section includes general information which can be useful for literacy coordinators and instructors.

The Canadian Charter of Rights and Freedoms in the Canadian Constitution

The Charter is beginning to be used to protect the rights of patients and may have considerable impact in the future. Lawyers and patients' advocates think it will help to stop common abuses which can occur during involuntary admission. Here are two examples of how The Charter may affect patients' rights.

CHALLENGING THE WELFARE TEST

A person fails the Welfare Test when a doctor decides that she/he is unable to react appropriately toward others and to care for herself/himself. The issue here is what exactly constitutes the ability to care for one's self, and how poor does self-care have to be for a person to fail the test? If a life is at risk, the answer is clear. However, is hospitalization necessary when a person is very dirty, eats garbage, and sleeps on park benches? A legal precedent was set in 1983 when a judge ordered the release of a person confined against his will under the Welfare Test. The judge said that without

Box 12

Paul's Story

Involuntary Admission Under the Criminal Justice System

Paul is arrested for stealing. While he is in his cell awaiting his trial, he is overheard talking to himself. When he meets with his lawyer before his trial, the lawyer can't understand what Paul is saying. His thoughts seem disordered.

Is Paul 'fit to stand trial'?

If his lawyer or the judge suspect that Paul is mentally disordered so that he cannot understand the difference between pleading guilty or not-guilty and he can barely talk with his lawyer, the judge may order a psychiatric examination to determine whether Paul is mentally 'fit to stand trial'.

Remand observation

Paul is sent to a forensic ward in a mental hospital for a psychiatric examination. This makes Paul an involuntary patient. He may be examined for no longer than 30 days. After the examination, the psychiatrist reports her/his opinion to the court. This process is called remand observation.

Paul is 'unfit to stand trial'

The report states that due to a mental disorder Paul does not understand the court proceedings. Therefore, another trial is held to determine if Paul is 'unfit to stand trial'. The burden of proof is on the prosecutor, who uses the psychiatrist's report as evidence. In this trial Paul is found to be 'unfit to stand trial'.

What happens next?

As long as he is 'unfit to stand trial', Paul will be held in custody as an involuntary patient. A disposition order made by the judge outlines how long Paul is to be held and what his treatment will be. His fitness to stand trial must be retried every two years until he is found fit to stand trial or he is released from custody. Until this happens, Paul remains an involuntary patient.

What if Paul was mentally disordered when he committed the theft?

Perhaps during a delusion Paul believed that what he took belonged to him. In this case either Paul, his lawyer, or in some cases the prosecutor can ask the judge to have Paul examined for the verdict of 'not criminally responsible on account of mental disorder'. Paul is sent to remand observation, just as in the case of fitness to stand trial.

'Not criminally responsible on account of mental disorder'

The psychiatrist testifies in court that Paul has a mental disorder which prevents him from understanding that what he did was wrong. If this is the verdict of his trial, Paul is 'not criminally responsible on account of mental disorder'. The judge holds a special hearing and passes an order which states how long Paul will be an involuntary patient and what his treatment will be.

How long can Paul be an involuntary patient?

Under an old law Paul could be held for an indefinite period of time. A new law limits the length of his involuntary status, which depends on the nature of his offense.

Reviewing Paul's involuntary admission

Under the new law each province must have a Review Board. The Board acts like a court set up to review the cases of people held in custody as 'not criminally responsible on account of mental disorder'. The Board can make disposition orders stating how long Paul will be an involuntary patient and what his treatment will be. For instance, the Board determines whether Paul can get passes to visit or work in the community while he is confined at the hospital. Paul may be represented at the Review Board by a lawyer.

Information in this case is based on Robertson, 1988 and Wilson, 1992.

Box 13

Jack's Case

The Physician's Certificate: Or Who Can Put Jack into a Mental Hospital and How Can He Get Out?

Who can put Jack in?

Jack is driven by his friend to a walk-in clinic in a general hospital because Jack is very upset and has threatened to commit suicide. Jack's doctor at the clinic signs a certificate which puts Jack in a locked psychiatric ward of a nearby hospital. This makes him an involuntary patient.

What was the doctor's certificate?

The doctor examines Jack and diagnoses him as depressed and possibly suicidal. He issues a certificate. The certificate must be issued for a definite period of time, normally no longer than 7 days; however, this varies depending on the province. The doctor issues the certificate because he believes that Jack is suffering from a mental disorder.

An alternative: a police arrest

A police officer finds Jack sitting on a curb trying to cut himself. The officer arrests Jack and drives him to a mental hospital instead of the jail. In most provinces the officer must take Jack to a 'mental health facility', not just a local doctor. A psychiatrist examines Jack to determine whether to issue the certificate, or Jack may choose to be admitted as a voluntary patient.

He can be kept in the hospital as an involuntary patient for up to 7 days, depending on the province's Mental Health Act. Jack can be confined for more than 7 days if the certificate is renewed. Two docters must sign a new certificate. Then Jack is admitted. He may be moved to a mental hospital in another area.

Who can let Jack out?

Jack can be discharged by the psychiatrist. When the certificate expires and if it is not renewed, Jack may leave. He may be discharged before the expiration of his certificate if a psychiatrist believes that he no longer needs treatment.

Jack can also be released by an order from a Review Panel. The Mental Health Act establishes a Review Panel to which Jack may apply to have his involuntary admission revoked. In most provinces either Jack or someone he knows can apply. A Review is not automatic, except in some provinces where Jack would get an automatic review after a fourth renewal certificate had been signed. The number of appeals to the Review Panel are restricted. In some provinces, Jack may apply to a court judge to review his involuntary admission.

Habeas corpus

Anyone, including Jack, who is held in custody has the legal right under the Canadian Charter of Rights to have the lawfulness of his detention examined by a court. This is called the right to apply for a writ of habeas corpus.

Information in this case is based on Robertson, 1988.

proof that a person is dangerous and with no real way to prove the validity of the test, the practice violated a person's rights.

THE RIGHT TO REVIEW

Involuntary patients have the right to challenge their confinement before a provincial Review Panel. In most provinces, the patient must formally request a review. In some provinces, a hearing by a Review Panel is automatic after a commitment certificate has been renewed. In two provinces (New Brunswick and P.E.I.), a Review Panel must consider a patient's appeal but they can still deny the patient a hearing. So much variety causes problems. In 1987 a judge ruled that under The Charter a patient has the right to apply for a review, to be represented by a lawyer, to call witnesses, and to question those who issued the certificates.

Provincial Mental Health Acts

Patients' rights, in so far as they exist, are written into each province's Mental Health Act. There is a great deal of variation among these acts. Moreover individual acts have been changed overtime. Alberta, for instance, recently revised its Mental Health Act and the changes affect patients' rights. While we cannot provide a detailed description of the rights in each province, we can identify some general rights and raise some issues with which instructors and learners should be familiar.

THE RIGHT TO REFUSE TREATMENT

A person must give consent to treatment. But there are important exceptions to this rule.

- In an emergency, usually treatment may be given to preserve the life or well-being of a patient.
- Only under certain circumstances can treatment be given to involuntary patients without their consent.
- In many provinces, involuntary patients have the right to refuse treatment, unless the doctor declares that the person is incapable of giving consent. In this case the doctor needs the consent of the person's guardian or next-of-kin. The decisions are subject to Review Panel procedures.
- There are restrictions concerning the use of ECT and psychosurgery. In Ontario, for example, a Review Panel cannot order psychosurgery or ECT against a patient's will.
- People detained because they are 'not fit to stand trial' or 'not criminally responsible on account of mental disorders' (See Box 12) cannot be treated without their consent.

THE RIGHT TO CONSENT

In most provinces a person does not lose her/his right to refuse treatment simply because she/he is committed under a Mental Health Act. The capacity to give consent is separate from commitment. If the person lacks the capacity to give consent, and the situation is not a real emergency, substitute consent (e.g. consent by next-of-kin) is required.

THE RIGHT TO BE INFORMED AND HAVE A LAWYER

Some provinces require that patients be kept informed of the reason for their involuntary admission and of their right to apply for a review. In several provinces and the Yukon, people must be informed of their right to be represented by a lawyer at a Review Panel hearing.

THE RIGHT TO REVIEW OF CONFINEMENT

Most provinces have a Review Panel to which patients can apply to have their involuntary status reviewed. The Panel usually includes a psychiatrist, a lawyer, and a representative of the public. Only involuntary patients may apply for a review in Canada. People sent to mental hospitals for psychiatric assessment related to a criminal case (See Box 12) may not apply.

Patients or anyone acting on behalf of a patient may apply for a review. Alberta, Manitoba, Ontario, and Saskatchewan's Mental Health Acts require automatic reviews; patients in other provinces must apply formally. Most provinces restrict the number of times an application for review can be made and usually one review is permitted for each commitment or certificate (see Box 13).

THE RIGHT TO CONFIDENTIALITY

Psychiatrists, like all doctors, are ethically and legally bound to protect the confidentiality of information relating to their patients. In mental hospitals, confidentiality restrictions apply to everyone who works in the hospital. Detailed, formal rules establish the limited conditions under which a doctor or mental health worker are required to provide confidential information. For example, following an important ruling by the California Supreme Court, doctors must breech confidentiality if someone's life is endangered.

THE PATIENT'S RIGHT TO SEE HER/HIS RECORDS

Patients have the right to see their records unless there are exceptional circumstances. If refused, a patient may apply to a court to see her/his records. In some provinces, certain people (e.g. ministers) can have access to a patient's file if they are acting on behalf of the patient.

THE RIGHT TO COMMUNICATION

In a few provinces a patient's incoming and out-going mail can be examined and censored. In Ontario a patient's out-going mail may be examined and withheld if there is good reason to believe the communication from the patient will be harmful or offensive to the person who receives it. Written communications between a

patient and a lawyer, a member of a Review Board, a Member of Parliament, and members of provincial legislative assemblies may not be examined or withheld by anyone.

THE RIGHT TO PERSONAL SECURITY - PROTECTING THE PATIENT

Mental health workers have a legal duty to make sure that a person does not harm herself/himself (e.g. commit suicide). The risk of doing harm must be a real risk based on the person's history and mental disorder. Mental health workers who do not confine in a hospital someone who later commits suicide may be sued for damages and held responsible for the death.

THE RIGHT TO PERSONAL SECURITY - PROTECTING OTHERS

Mental health workers and hospitals are required to protect the safety of others, including other mental health workers. This may lead to putting someone in a locked room for close observation or in physical restraints. If a person escapes from a hospital and causes harm, the hospital can be held responsible for the damages.

THE FREEDOM FROM DISCIPLINE

Hospitals have a responsibility to protect patients from harming themselves or others. In some cases this may lead to the use of restraints and seclusion. In a few provinces the Mental Health Act deals with the problem of inappropriate use of restraints and seclusion. In some provinces the limits are unclear. At best, there is the vague requirement that unnecessary discipline should be avoided.

Treatment Issues

Limited success with therapies that are supposed to reduce or cure mental disorders, cases of patient abuse, apparent biases in who does and does not get treated for disorders, and changing social standards about what is or is not 'abnormal' behaviour have led to concerns about treatments for mental disorders. Some of these concerns should be mentioned here in order to increase awareness. Materials listed in the Resource Guide provide information for those who would like to examine these issues in greater depth.

DEFINING NORMALITY

Therapy is meant to change behaviour associated with mental disorders. Some behaviours (e.g. violent outbursts) are generally recognized as more unacceptable or harmful than others. Some groups may view a behaviour as socially acceptable (e.g. smoking marijuana), while others believe it is not. Some groups have the political power to transform their values into rules and laws. Thus, value judgements and power enter into discussions about mental disorders. There is considerable concern about the authority of mental health workers to say what is or is not acceptable behaviour, especially when social norms are known to fluctuate with time. For instance, until quite recently homosexuality was considered a mental disorder.

THERAPY AND CONTROL

Some treatments and methods used to keep people from harming themselves and others (e.g. sedative drugs and seclusion rooms) have been criticized as being thinly disguised forms of coercive control. Government investigations, for example, have documented incidents where treatments have been abused. Cases exist in which therapies have been used simply to occupy patients' time rather than to prepare them to live productively in the outside world. Psychiatrists are aware of these problems. However, they point out that there is a difference between saying that therapies are abusive when they are used as forms of control or punishment and saying that all therapies are inherently forms of control and punishment.

IDENTIFYING WHO SHOULD BE TREATED FOR MENTAL DISORDER

Cases arise in which two psychiatrists testifying in a courtroom come to very different conclusions about the mental health of the defendant. A psychiatrist gives this example of differing testimony of two psychiatrists.

> First psychiatrist: *"After careful examination, it is clear that Mr. X is schizophrenic. It is quite unlikely that he knew that what he was doing was wrong."*
>
> Second psychiatrist: *"I have had ample opportunity to examine the defendant. It is clear that he is rather eccentric and may be suffering from a personality disorder; however, he is not schizophrenic. He knew very well that what he did was wrong."*

Psychiatrists working in these situations have expressed serious concerns about the demands placed on psychiatry by law enforcement agencies. For instance, several years after a murder was committed, it may be very difficult to establish whether the defendant was able at the time to differentiate between right and wrong. Psychiatrists are also asked to predict whether a particular person is dangerous. This is a difficult thing to do. Because a mistake could lead to disaster, psychiatrists may be too quick to label an individual as a potential danger if released from custody.

These and similar legitimate concerns about the accuracy of psychiatric diagnoses should not be distorted by turning them into an argument for condemning psychiatry outright. The concern is well placed if it helps us to recognize the limitations of psychiatric diagnoses and treatments. In psychiatry, knowledge is only partial knowledge and change is constant. People work under the constraints of limited resources and incomplete information. And like teachers, mental health workers are people first and professionals second.

CONSENT TO TREATMENT

As a general rule patient consent is required before any form of treatment is used. Voluntary patients have the right to refuse treatment and some involuntary patients

may do the same. However, as discussed earlier in this chapter, voluntary patients may agree to treatment because they fear becoming an involuntary patient. Also, lack of information about alternative types of therapies used by psychiatrists creates situations in which people do not have a genuine choice. Real consent means having real options. If nothing but one kind of therapy is offered or if alternatives are dismissed as impractical or nonsense, consent to therapy is best described as consent in name only.

THERAPY AND TEAMWORK

In hospitals mental health workers strive to work together as a team. This is a multi-disciplinary approach to treatment. Therapists working with a patient exchange information in a case conference. Each therapist reports problems and progress with the patient. The results of psychological tests are reported. Important entries in the patient's file may be read to the multi-disciplinary team. The idea behind the case conference approach is to create a more holistic therapy. While drug therapy may be the primary treatment, input from other therapists may uncover problems and treatment strategies which would otherwise go unnoticed.

However, hospitals (like most big institutions) operate as bureaucracies. Authority is usually top-down. Some groups (e.g. service directors) have more status and authority than others (e.g. social workers). Furthermore, hospitals are based on the medical treatment model. Other therapies may be viewed by the medical staff as secondary treatments, and those who provide these therapies may feel that they take a 'back seat' when decisions are made in case conferences. Teachers in hospital settings report that their suggestions are not taken seriously by medical staff. They are not alone, as this social worker notes.

> *"It's very difficult to be heard in a case conference unless the psychiatrist is willing to listen to what the other therapists have to say. Some do. In some places there really is a team approach, but that's rare. And even when it does exist, it's only because the doctor agrees to it. If he doesn't like a therapy or social workers - just as an example - then you can forget it when it comes to having your opinions heard or taken seriously. I've been in some case conferences with school teachers, and they're lower in the pecking order than anyone else. They're 'new on the block' and no one really knows how their work is supposed to fit in."*

In Chapter Four a section on developing a working relationship with mental health staff discusses what teachers can do to help reduce problems related to working with therapists in a multi-disciplinary treatment program.

Chapter Three

MEMORY AND MENTAL DISORDER

MEMORY involves the ability to store and retrieve information. Memory is essential for learning. Therefore, memory problems related to mental disorders and treatments create significant difficulties for students. This chapter provides general information on memory and how it is affected by mental disorders and medical treatments. At the end of this chapter, several teaching methods for improving memory are suggested. Many of these methods are good adult education practices that can be used with any student. Some of them are especially recommended for students being treated for mental disorders.

The Memory Process

Think of memory as a complex storage and retrieval process. Different kinds of information are stored for varying lengths of time and are retrieved in different ways. For instance, a child remembers not to touch a flame and an actor memorizes the lines in a play. Some information, like your own name, is stored for a lifetime and retrieved often. Other information is stored for a few seconds and retrieved only once. Some information is retrieved without effort, like remembering your birth date. Other kinds of information cannot be retrieved without assistance, which is why, for example, people use shopping lists.

Short-term and long-term memory

Information is gathered by our five senses and sent to the brain where it is stored in sensory memory, in much the same way as it is taken in from the environment. For example, an animal's image is stored as a visual image. Most information stored in sensory memory is forgotten in a few seconds as it is continually being replaced with new information.

If a person pays more than passing attention to a piece of sensory information and then makes an effort to remember it (e.g. looking closely at a map), a portion of the information that is in sensory memory goes to short-term memory (also called immediate memory and working memory). It is called short-term because the information is stored

for about thirty seconds. Only a small amount of information can be stored in short-term memory. If too much is stored at once, information is quickly forgotten.

When information is needed for more than a few seconds, it can be stored in long-term memory, which has two storage banks. One is called delayed memory. Information is stored here for several minutes or hours. The other storage bank is called remote memory. Information is stored here for a very long time, even a lifetime. The capacity of long-term memory is enormous, perhaps unlimited.

In long-term memory, information is related to other information. For example, when a person stores the word 'apple' in long-term memory, information about the meaning of the word, the colour and taste of an apple, and the fact that it can be eaten are linked to the word.

We can think of short-term memory as a stack of information placed on a desk. Practice puts this information into the filing system or long-term memory, where it can be stored for daily use or for a lifetime.

Rehearsal or practice

To store information in short-term and long-term memory, it must be rehearsed or practiced. For instance, you can keep a number in your short-term memory by repeating it several times. More practice results in information being stored more permanently in long-term memory.

If there is a lot of information to be stored, rehearsal becomes more complex. Studying, for example, is a complex form of rehearsal or practice. Learners may use mnemonic devices, techniques for making rehearsal more effective. For instance, to store the names of the Great Lakes, a person may use the word HOMES as a mnemonic device for Huron, Ontario, Michigan, Erie, Superior. Especially meaningful information (e.g. a startling event) may be stored without rehearsal. This is called flashbulb memory.

Automatic and effortful processing

We can also distinguish between two types of practice: automatic and effortful processing. The difference between the two is the amount of attention required to store information in long-term memory. Automatic processes means very little attention or effort is needed to store information. For example, a little girl hears her mother's name said many times and without paying much attention, she stores the name in her memory. Rehearsal is nearly automatic and so the process is called automatic processing. Effortful processing involves sustained attention, the ability to filter out competing sights and sounds, and the complex ability to alternate attention (i.e. the ability to switch from one activity to another and back again). Much practice is necessary. Learning to read requires effortful processing.

Retrieval

Information is taken out of storage and transferred into some thought or action

(e.g. spelling a word) through a process called retrieval. Many mental strategies are used to retrieve information. Two important ones are recognition and recall.

Recognition uses cues to retrieve information. For example, recognition is used when a student is shown the alphabet and is asked to find the letter 'A'. The student recognizes the letter from among twenty-six choices. Recall is the ability to retrieve information without clues. Recall is used when a student spells words while writing a letter. Recall requires more effort than recognition.

Types of Memory

What we remember varies according to the kind of information being stored. Consider for example the colour of a cat and the sound of its cry. Its colour and cry, when we remember them, will be quite different from the cat's actual colour and the actual sound it makes. By contrast, telephone numbers are remembered exactly as they are. Here are some other differences in the types of information that enters the memory process.

Auditory and visual memory

Auditory memory is the storage of information which is heard. Visual memory is the storage of information which is seen.

Performance skills and verbal skills memory

Performance skills (or motor skills) memory is memory for information that controls physical movement. This involves storing information about how to hold and use a pencil, draw a picture, and activities requiring coordination. Of course, motor skills may involve language, but the critical information has to do with body movement. Verbal skills memory involves storing and retrieving language information.

The Effects of Mental Disorders and Treatments on Memory

Mental disorders and some treatments adversely affect memory. Comments from this instructor make this very clear.

> *"He has trouble remembering words. If I ask him to give me another word for car, he can't. But if I put five words down and ask him to find one which means car, he'll get it. He has little memory for things from one mo-*

ment to the next. He'll read two paragraphs and not remember a thing when we go to the questions."

Another instructor says:

"The problem is memory. He can't stay with it for more than a few minutes. It's pretty intense and it's hard to keep up that intensity. We'll talk about what he did before his accident. But [ask] him what he did yesterday, or even when we started working fifteen minutes ago, and he can't say. He realizes he has a problem. It's a pretty sad business."

A student conveys his experience.

"I try to read on my own, but I get lost. I'll start to think about something else. Now art, I like that and I do pretty good."

The first student was being treated for schizophrenia, the second for brain injury, and the third for manic-depression. These comments exemplify problems students have with storing and retrieving different types of information (e.g. performance and verbal skills) that are related to both mental disorders and the treatments used to control these disorders. We need to examine these problems in greater detail.

Effects of schizophrenic and paranoid disorders on memory

These disorders may adversely affect the memory process. Problems arise when students attempt to store information in both short-term and long-term memory, with the greater problem being storage in short-term memory. When students try to retrieve information, they have more difficulty with recall than with recognition. Auditory and/or visual memory may be impaired, and verbal skills are usually weaker than performance skills.

One explanation for these problems is that students treated for these disorders have great difficulty with effortful processes. Recall that effortful processing requires sustained attention as well as the ability to filter out competing sights and sounds and to alternate attention. These abilities require focused concentration. Hallucinations, thought disorders, and delusions create attention deficits. A picture in a book or a sound from a hallway may trigger a delusion and attention is lost. This student's comment illustrates the point.

"My mind is flying all over my work and I can't seem to assimilate. I can't recognize what I've done. I can't seem to remember what I did yesterday. Someone asks me to think about a problem or something and I find that I can't think. I have to go back over anything I learn, many, many times. I rely almost entirely on what I learned before I got sick."

Problems with selective and alternating attention are described by this student.

> *"I need help with remembering little things because I don't pay attention. I'm not paying attention right now. I get distracted pretty easy. If there were a dog barking outside, I'd listen to that. I can't stand a lot of noise when I'm working. I come to a word like that one there and I start playing around with it."*

A psychiatrist observes:

> *"For most, verbal skills are weak. A patient may be very good with art and puzzles and do really well in recreation, but reading and writing skills are weak. And that's rather typical: weak verbal skills but okay on performance skills."*

Effects of drug treatments for schizophrenic and paranoid disorders on memory

Antipsychotic drugs are used to treat schizophrenic and paranoid disorders. Antiparkinsonian drugs are used to control side effects of antipsychotic drugs (See Chapter One).

These drugs may improve the memory process. Since antipsychotic drugs reduce the incidence or intensity of delusions, hallucinations, and thought disorders, the student's ability to pay attention and concentrate should improve. Unfortunately, the side effects of these drugs can also aggravate memory problems, as illustrated by this student's comment.

> *"I come to school every day and I have to think hard to remember what he said the day before. I might have to go over it again until I remember it. Sometimes it takes a week of going over it. I thought I'd quit because I'd forget, but I've decided to stick it out. I wish I could get my meds changed because I think the ones I'm using now make it worse."*

An instructor makes this observation about some of her students.

> *"When they take Modecate injections, they forget what they learned in the past few days and we don't get much done for a while afterwards. See, this is the progress we made just before they took their meds. We got up to here. Now we're back here. So you keep going back over material. I don't think it's the illness as much as it's the Modecate, because I don't see the problem until just after they take it. I guess if they didn't take it, there would be other problems, but that's what I see."*

Research on the effect of drugs on memory confirms these observations. One

study, for example, identified certain antipsychotic drugs which adversely affect the 'general learning ability' required for memory. Artane is an antiparkinsonian drug which creates problems with short-term memory, but retrieving information from long-term memory is not affected.

Drowsiness is a side effect of antipsychotic and antiparkinsonian drugs which may have an indirect effect on the memory process by hindering the ability to pay attention and practice. The following antiparkensonian drugs are likely to cause drowsiness: Artane, Benadryl, Disipal. The following antipsychotic drugs may cause drowsiness: Clozaril, Fluanxol, Largactil, Loxapac, Mellaril, Modecate, Stelazine.

Note that mental health workers have expressed some reservations about the negative influence these drugs have on memory. Their major reservations are that:

- It is not always possible to determine how much of the problem is caused by the disorder and how much is caused by the drugs.
- Other disorders may complicate memory problems (e.g. older adults suffering from dementia).
- Problems initially caused by a medication may pass after a period of time.

We can conclude from these reservations that while these drugs may benefit some memory processes when they control the thoughts and behaviours related to schizophrenic and paranoid disorders, they may also create memory problems. Not all antipsychotic and antiparkinsonian drugs have the same negative impact. Some may affect only certain parts of the memory process, while some may have an indirect effect. Instructors and students should realize that schizophrenic and paranoid disorders and the drugs used to treat them may create serious problems for the memory process.

Effects of depressive and manic-depressive disorders on memory

These disorders can make storing information in short-term and long-term memory difficult. Both the ability to recognize and recall information can also be impaired. It is likely that these problems arise because depressive and manic-depressive disorders create attention and rehearsal deficits.

Feelings of helplessness and restlessness, having low motivation, and related characteristics of depressive and manic-depressive disorders may distract the person who is trying to pay close attention to what she/he is hearing or seeing. When it is time to practice storing the information in long-term memory, these feelings may continue to distract the learner; thus, practice produces few results. Learning which may be almost automatic for an adult who is not depressed requires a great deal of effort for the person who must overcome attention problems. As one psychologist puts it, 'Memory problems in depression reflect problems allocating sufficient effort to increasingly difficult tasks.' A student puts it like this.

> *"If I can control my moods I'm okay. If I get angry, then I can't think about school work until I become happy again. I get anxious about what I'm doing and where I'm going. I think about it and school doesn't matter much."*

Auditory and visual memory are not hindered by these disorders per se; that is, there is not some organic or perceptual problem which makes remembering what is heard or seen difficult. Verbal skills, important for literacy education, are usually unaffected. Performance skills are frequently weak, which is significant for students involved with learning physical activities (e.g. sports).

Effects of treatments for depressive and manic-depressive disorders on memory

Because the treatments for depressive and manic-depressive disorders reduce feelings and thoughts which interfere with the memory process, they are likely to have positive influences on memory. However, some of their side effects can aggravate memory problems.

ANTIDEPRESSANTS

The following antidepressant drugs are those most likely to affect directly concentration and memory: Nardil, Asendin, Elavil, Pertofrane, Sinequan.

A student speaks about her experience.

> *"I'm depressed. Before I thought I was alright for studying, but I didn't do much. I started school here. The drugs made me tired so I couldn't pay attention in class. The doctor must have adjusted my meds, because I could do better after a while."*
>
> *"Can you concentrate?"*
>
> *"When I work alone? Not too much. I lose interest or I start thinking about things I'm worried about. I don't do that as much now. But I still worry a lot."*

These effects can be more or less significant. For many the negative effects pass as the body adjusts to the drugs. It is not easy to determine how much of a difficulty with concentration is a behaviour related to the disorder. Nonetheless, comments by instructors, students, and mental health workers indicate that the side effects of antidepressants cannot be ignored as a possible explanation for memory problems.

ELECTRO-SHOCK THERAPY (ECT)

ECT is used to treat severe depressive disorders. There is a great deal of controversy over the use of ECT because it adversely affects memory for varying periods of time and with varying significance. This psychiatrist observes:

> *"Patients become quite alarmed. They're concerned that ECT will interfere with their memory. ECT does create memory deficits, but the effect isn't prolonged. The teacher should allow for a period, less than a*

month. The patients can tell when their memory is recovered. The teacher will just need to ask."

Studies show that autobiographical memory (i.e. memory of one's past) is impaired for some time after ECT treatment and it may create problems with memory for performance (motor) skills, but verbal memory seems less affected. Memory which records facts and events is impaired more than memory for how to perform tasks and follow procedures. A student who received many ECT treatments, expresses concern.

"I thought that I'd never be normal again. My memory went. I couldn't remember dates - things like that. My memory was slow. I'd have to think. Now I'd say that my memory is back, but for a while I thought it was hopeless."

An example of how ECT may both hinder and improve memory is provided by a study of people whose memory before treatment was quite poor. After the ECT their ability to recall information stored in long-term memory improved, but as a group they had more trouble retrieving information using recognition. Six months later this problem passed and as a group their memories improved.

LITHIUM AND TEGRETOL

These drugs are used to treat manic-depression. Side effects of Lithium which interfere with memory process are poor concentration and mental confusion. In one study a group of 49 people being treated with Lithium were asked to rate the side effects most troublesome to them. Mental slowness, confusion, and memory problems were at the top of their lists and bothersome enough to cause them to stop taking the medication against their doctors' advice.

Tegretol, a Lithium alternative, is also reported to have a negative effect on memory although, just as in the case of ECT and Lithium, it is difficult to say if problems are caused by the drug or the disorder. Among the common side effects listed for Tegretol are confusion, memory impairment, and sedation. Patients are told that until the doctor determines how they react to Tegretol, they should avoid activities which require alertness.

In summary, treatments for depressive and manic-depressive disorders seem to improve the memory process by controlling the thoughts which interfere with effortful memory processes. However, these treatments may aggravate attention and rehearsal deficits associated with depressive disorders, making effortful memory processes even more difficult to accomplish.

Effects of substance abuse on memory: alcohol and glue sniffing

Alcohol and glue sniffing are two substance abuse disorders which adversely affect short-term and long-term memory. A literacy coordinator working with a young adult being treated for glue-sniffing says:

"He didn't seem frustrated with his progress, actually he didn't seem to notice that he was having problems. He liked being here, but his self-esteem was very low, absolutely no confidence. He didn't remember anything from one class to the next, but I don't think he noticed, or he just didn't care."

There are several disorders related to alcohol abuse and glue sniffing which have a direct impact on memory. These disorders are described as 'brain dysfunction', a state which occurs when the brain's capacity to store information has been damaged.

Dementia is a permanent long-term memory loss and inability to think abstractly. Korsakoff's Syndrome (referred to in Chapter One) leads to irreversible long-term memory loss. It occurs in advanced stages of alcohol abuse.

Memory problems may also be related to attention and rehearsal deficits. Alcohol is a depressant and affects a person's ability to concentrate. The ability to practice is poor because the person is easily fatigued and distracted, and this hinders effortful memory processes. Information is learned in bits and pieces, which creates confusion, misdirections, and problems for completing tasks. This may lead to increased frustration, which makes practicing more difficult.

Effects of treatments for substance abuse on memory

Treatments for substance abuse are almost exclusively forms of psychotherapy and behaviour therapy. In the case of alcohol abuse, Antabuse is a drug taken to curb the desire for drinking. Some drugs are used to treat narcotics abuse. These treatments are quite likely to have a very positive effect on memory and learning. They do not seem to have a noticeably negative influence on memory.

Effects of anxiety disorders on memory

Anxiety disorders, social phobias, agoraphobia, and panic disorders (see Chapter One) do not seem to affect directly the memory process. However, fear of an impending panic attack, attending group activities, and so forth may indirectly hinder memory by creating various attention deficits. In this way anxiety disorders can make effortful learning difficult.

Effects of treatment for anxiety on memory: antianxiety drugs

In so far as antianxiety drugs reduce the thoughts and behaviours characteristic of anxiety disorders, they improve the memory process. Antianxiety drugs, however, may cause drowsiness, especially in the early stages of treatment, creating attention and practice deficits which affect memory.

Effects of brain injury on memory: indirect effects

Brain injury can have a profound impact on all aspects of the memory process. It

results in problems which indirectly impair memory.

FATIGUE

Fatigue is a common problem for individuals with head injury. It results from the extra physical demands and emotional stress related to coping with disabilities. Following a brain injury, learning is almost all effortful learning; therefore, learning contributes to fatigue. Attention, concentration, and memory storage processes are impaired by fatigue.

DENIAL OF DIFFICULTIES AND LOW SELF-ESTEEM

These problems are associated with the adjustment to disabilities caused by a head injury. Indeed, a major characteristic of brain injury disorder is the depression and frustration associated with coming to grips with realistic goals for each day and for the future. How this affects memory is clear from this instructor's comment.

> *"He gets angry at me because I don't give him harder words or a longer spelling list. The truth is that he can't spell half of the words. At best we'll work with two or three words a day. And he really can't remember those the next day. This guy had a trucking company. Now he can't remember much from one day to the next, but he knows what he could do before. It's hard for him and it's pretty hard on me, if I can say so."*

ATTENTION DEFICIT

Attention deficit created by brain injury is perhaps the most common problem. The individual may have difficulty sustaining attention for more than a few moments or focusing on what is being said and filtering out extraneous sensory information. The ability to switch attention from one thing to another and back again may be impaired. An attention deficit means that no information is being stored in the memory, or that only fragments of information are being stored, which creates confusion.

AWKWARD BEHAVIORAL EFFECTS

Behaviours which are seen as socially unacceptable create a stigma, which can lower the person's self esteem and make it difficult for her/him to work with others. The awkward behaviours may include increased impulsive behaviour, poor judgement of others, and exaggerated physical movements and emotional expressions (e.g. inappropriate laughing or crying). These can create a chain reaction, as this instructor observes.

> *"It's not so much her; it's the others who become upset. The place changes. Everyone gets uptight, and by the time things have quieted down, she's embarrassed, and nobody knows what they were doing. It's really very difficult for her and the others."*

DIFFICULTIES WITH ORGANIZING, PLANNING, AND SELF-EVALUATION

These problems make practice difficult to accomplish. For instance, a major

strategy for storing information in long-term memory is using mnemonic devices (See Box 17). To use them you need some ability to reorganize information. Chunking, for example, requires the ability to organize information into smaller, more manageable parts (e.g. 4569872 is changed to 456-9872). In addition to affecting organization skills, brain damage may affect the ability for self-evaluation, as illustrated by this instructor's comment.

> *"She says, 'I've got it. Let's go.' I get that all the time. She's in a rush. It's also her injury. She really doesn't have much of a clue about whether she knows the word or the answer. I don't think she can tell. It's more she wants to know it, not that she does."*

Effects of brain injury on memory: direct effects

Brain injury directly affects the memory process. Organic damage may impair the ability to store and retrieve information or store and retrieve certain types of information.

INJURY TO MEMORY STORAGE AND RETRIEVAL

Injury to memory storage creates difficulties which are extremely frustrating since they usually hinder the ability to store new information. What the person knew prior to her/his injury may be intact, but there is a partial or total inability to store new information no matter how often or in what way the person practices. Students with the most severe cases are not likely to be in a literacy program, but students with less severe problems often are. A student comments:

> *"I didn't go on but I finished high school and I was a whiz at math. I should have gone to Alberta College. Well, anyhow. Now it takes forever to learn a single new thing. We've worked on it for years. It used to drive me nuts. I've come to live with it."*

AUDITORY AND VISUAL MEMORY

A head injury may damage centres of the brain which store sights but leave centres that store sounds unaffected. Or the reverse may occur. If auditory memory is impaired, the person requires frequent repetition of what is being said before information is stored. If visual memory is impaired, the student may need to refer to written information several times before the information is stored in short-term memory. As in the case of auditory memory, many rehearsals will be needed to store the information in long-term memory. Note this student's example.

> *"I'll take a list, just to show you, and I'll read it. Then I'll go to do the first thing and I have to go back to the list. Not once or twice, mind you. I've got to do it bunches of times. But if you tell me what to do, like you say, 'go do this, then this, and then that,' I can remember. Maybe you'll have to say it twice."*

Effects of treatment for brain injury on memory: anticonvulsant drugs

Anticonvulsants are sometimes used to control the characteristics of brain injury disorders. They may aggravate already existing memory problems. Two commonly used anticonvulsants may cause drowsiness, which contributes to the problem of fatigue. The common side effects of Dilantin, for instance, include decreased mental alertness, double vision, and insomnia.

Strategies to Improve Memory

Many specific problems and strategies that will be described in Chapter Five relate to the information on memory explained here. In this section the focus is on teaching methods that are appropriate for use with any student for improving memory. Boxes 14, 15, and 16 provide information for you to use when designing lessons. For instance, information in Box 16 shows that not all students learn best from reading. Some learn best by listening, while others learn best if lessons include physical activity.

Box 14 — **Memory Essentials**

When developing strategies to improve the memory process, remember these basic principles about memory.

It's easiest to remember what is **FIRST** in a sequence.

Concepts **LINKED** or associated with other concepts are easier to remember.

People remember information that is **MEANINGFUL.**

When information is **ORGANIZED** into a pattern, it's easier to store and retrieve.

Information that is somehow **OUTSTANDING** or unusual is easiest to learn.

People remember **PERSONAL** information.

Memory depends on information being **REVIEWED** and practiced.

Many of the strategies recommended here improve memory by improving attention. This is precisely what is needed by many students with mental disorders. While each mental disorder and treatment may adversely affect the memory process in different ways, it is clear that most disorders and drugs cause attention problems. At the end of this section are some strategies for specific memory problems (e.g. accommodating ECT's impact on memory).

Box 15 **Learn By Doing**

These percentages remind us that people remember best by doing.

We remember **10%** of what we **hear.**

We remember **15%** of what we **see.**

We remember **20%** of what we **hear and see.**

We remember **40%** of what we **hear, see, and do.**

We remember **80%** of what we **experience directly or practice with coaching.**

We remember **90%** of what we **teach others.**

USE THE BODY

Teach students to place their bodies in a position which makes paying attention easier. The main idea is to direct the eyes and ears of the learner toward the source of information and to reduce physical activity which contributes to distraction. Teach students these simple behaviours.

LISTENING
1. Look at the speaker.
2. Lean forward.
3. Avoid distracting movements (e.g. 'fiddling' with a pen).

READING
1. Place reading material directly in front of you.
2. Have only materials which you are reading on your desk.
3. Avoid distracting movements (e.g. 'fiddling' with a pen).

USE ASSOCIATION

When information is stored in long-term memory, it is linked to other information. This is called association. One bit of information is associated with others. Each association is like a hook. By increasing the hooks you have on a piece of information, you increase the ability to store it in long-term memory. An example is teaching words in related groups: grouping words for animals separately from words for plants.

REDUCE DISTRACTIONS

Attention is not one skill. Students may have trouble with sustained attention, the ability to stay focused on a task; selective attention, the ability to focus on one source of information against competing sights and sounds; alternative attention, the ability to shift effectively from one activity to another and back again; and divided attention, the ability to do 'two things at once' (e.g. listening and taking notes).

Each of these skills may be improved by using these four techniques for minimiz-

ing distractions. Teach students to use these techniques in order to create a learning environment that meets their needs.

- Have the student work in an area where traffic is minimal (e.g. a study carrel or behind a screen).
- Help the student to identify the types of sights and sounds that she/he finds distracting. Then assist the student in organizing the work space to reduce these distractions. For instance, if the student is sensitive to noise, suggest the use of earphones.
- Discuss with the student her/his needs to reduce distractions. Support her/his efforts to control the level of distraction instead of challenging her/him to work in a busy atmosphere.
- Provide short, structured activities. If the task involves the use of complex attention skills (e.g. divided attention), shorten practice time.

Box 16

The Memory Channels
The Visual, Auditory, and Kinaesthetic Learner

Some people best remember information they gathered through one sense. The visual learner remembers best what she/he sees or can visualize. The auditory learner remembers best what she/he hears. The kinaesthetic learner is the person who learns best by being physically active or involved. Learn the memory channel which is strongest for the student. Encourage her/him to use this strength to overcome memory problems.

THE VISUAL LEARNER

- Learns best by seeing pictures, films, demonstrations, charts, graphs, etc.
- Is able to visualize scenes described in books.
- Has a vivid visual imagination (i.e. she/he thinks in pictures).
- Makes written lists as a way to solve problems and remember.
- Remembers faces but forgets names.
- Organizes information by writing things down.

THE AUDITORY LEARNER

- Learns best by oral instructions, talk, lectures, etc.
- Prefers telling stories to writing them.
- Usually has a larger oral vocabulary than writing vocabulary.
- Can follow complex oral directions.
- Often remembers names but forgets faces.

THE KINAESTHETIC LEARNER

- Is usually well coordinated.
- Prefers to move around when reading and talking.
- Enjoys manual activities (e.g. crafts).
- Learns best by doing.

Practicing

Information is stored in memory with practice. However, increased practice is not always the best strategy for memory problems. The point is made by this experienced instructor.

> *"I think the first reaction to memory is to have the students do more rote learning, just lots of practice. But I don't think that's always the answer or even the best way to go - so much rote memory work. More emphasis on other skills is important. I try to teach them how to study so they can learn processes that help them to compensate for their memory problems."*

PRACTICE TIME

The length of practice time and the amount of information able to be learned at one time should be taken into account when practicing. It is important to recognize that there are two kinds of practice: massed practice and distributed practice. Massed practice means that the person keeps practicing until the information can be retrieved. Distributed practice means that a person practices for a set period of time, rests, practices again, rests, and so on. Which method of practicing is best depends a great deal on the type of information being learned and on who is doing the learning. Generally speaking, literacy skills are learned best with distributed practice.

DIVIDE TASKS INTO SMALL UNITS

The amount of information which can be stored in short- term memory is limited. Therefore, the memory process works best if the student attempts to learn only a small amount of information at one time. For instance, long lists of spelling words should be divided into several short lists. This student's comment emphasizes the value of dividing tasks into more manageable bits of information.

> *"If the teacher helps me to break the story down into sections, I can do it. But if I read the whole story then I have trouble remembering what I read. She's really good because she knows about how long the sections can be. We stop and she asks me some questions. Then we go on."*

An instructor says:

> *"It's very important that the material be short. One or two paragraphs is plenty for them to handle because you have people who have difficulty focusing their attention and that leads to problems remembering."*

When planning practice sessions, remember that each student's needs will vary. For some learning tasks, more practice will be necessary. Practicing is also affected by mood; that is, people have their good and bad days. Also, the side effects of medications are not always the same each day. Sensitivity to these variations will enable the student to work

most efficiently, and will help the student learn to monitor her/his changes and to adjust practice time accordingly. This instructor's comment illustrates this point.

> *"The student's retention was very poor so he required a great deal of repetition. But not always. There were good days and bad days. I have to watch out for these changes; otherwise he'll get frustrated by the repetition when he's feeling fine."*

USE A MEMORY NOTEBOOK

It is useful to have students keep memory notebooks. The student may:

- list daily tasks to be completed.
- store reference information for on-going use. A multiplication table, a list of rules for making nouns plural and placing 'i' before or after 'e' are examples.
- write notes while reading a story.
- write down instructions so she/he can proceed to work independently.

Since the characteristics of psychotic disorders affect organization skills, the instructor should assist the student in preparing and maintaining her/his notebook. Provide students with three ring binders that have dividers and inside pockets for pencils and pens. The notebook can become, as one student puts it, 'a part of me. I've gotten so used to carrying it around that when I don't have it, people notice.' This student goes on to talk about its usefulness.

> *"I take Stelazine and another drug. My memory is kind of bad. The teacher taught me to take notes all the time so I can remember things. I can remember old things, like what I learned before in school, but not new things. So I write everything down in steps. He reads something I'm studying out of the book. Then I read it with him. I read it again and each time I'm stuck, he says the word and I write it in my book. Then I go over to the computer station and type out the list. And we practice these words. Not just then but for weeks we go back to them. So I've got the words in my book and in the computer."*

Other strategies

Box 17 provides information about additional strategies for improving the memory process. A side effect of treatment which deserves special attention is drowsiness. Turn to Chapter Five for a discussion of drowsiness and strategies recommended for dealing with this problem.

PLANNING FOR ECT MEMORY DEFICITS

ECT has a direct effect on memory, but strategies for helping to minimize its negative effects are possible. Instructors should help students deal with their concerns about the impact of an ECT treatment on their memory and their future ability to learn.

- Because there are diverse opinions about ECT, collect information on ECT that expresses different points of view. The Resource Guide in the handbook includes articles with various viewpoints.
- Before the student receives ECT, talk about the effects it may have on her/his memory. This will prepare her/him for the temporary memory losses and will let the student know that you recognize these problems and are prepared to make allowances for them.

Box 17 — Improving Memory

Overlearning

Overlearning means practicing beyond the point of mastery. The advantage of overlearning is that students remember information for a longer time than if they stop practicing after mastery has been achieved.

Subjective organization

While practicing, learners impose their own organization on information to make remembering easier. This is called subjective organization. In addition to making learning easier, subjective organization improves the ability to remember information for a longer time.

General overview

Before reading a chapter or some other material which must be learned, the student should get an overall impression of the information that she/he is about to learn. This is called gaining a general overview. For example, before reading a chapter in a textbook, the student should begin by paging through it, noticing the sub-headings, reading captions under the illustrations, and reading the summary. Then she/he should return to the beginning of the chapter and read it through.

Mnemonic devices

Aids to memory are called mnemonic devices. Many mnemonic devices are commonly used. Here are four examples.

Chunking: Memory is improved by breaking material into manageable parts. Telephone companies chunk phone numbers to make them easier to remember. The seven numbers are chunked into two groups (466-7216). For spelling, syllables may be used as a form of chunking (de-pend-ing). Grouping in sets of three or five seems to work best.

Association: Material can be related to some other thing, thereby improving memory. For example, for the phone number 433-1975 the last numbers are associated with a date (1975).

Stories: Material may be turned into a story or poem. A famous example of this mnemonic device is: In 1492, Columbus sailed the ocean blue.

Anagrams: The first letter of a series of events, names, or concepts can be arranged to spell a word. For example, the names of the three prairie provinces make the word SAM: Saskatchewan, Alberta, and Manitoba.

As a result of overlearning and subjective organization, students often will invent their own mnemonic devices.

- Agree with your student on a plan for the period following ECT. This may involve postponing lessons entirely or planning lessons which allow for the anticipated memory deficits.

TEACH SELF-AWARENESS

Especially in the case of brain injury but also with other disorders and treatments, students need to be aware that the memory problems they experience are related to the disorder and treatment. The student has not suddenly 'become stupid.' It is not that she/he no longer cares about learning or is lazy. Instructors must take time to talk with

Box 18 — Self-Awareness Evaluation

Directions: After carefully explaining the purpose of the checklist (i.e. to improve self-awareness), help the student to complete Part One of the checklist. When the time is up, work with the student to complete Part Two.

Avoid too much coaching. The purpose is for the student to learn self-awareness through trial and error.

Be sure to provide time to discuss the results with the student.

Self-Awareness Checklist

Student's name _____ Date _____
Subject _____

Part One

1. Describe the learning task._____
(e.g. Read the story and complete the six questions at the end.)

2. Were the directions written or oral? _____

3. Units expecting to complete:
Time for the tasks_____(e.g. It will take 15 min.)
Pages of story_____(e.g. I'll read 3 pages.)
Questions answered _____(e.g. I'll finish 4 questions)

Part Two

1. Efficiency and accuracy:
Completion time _____ Pages read_____
Questions answered _____ Number correct_____

2. Attention:
Number of breaks_____
Describe distractions during the work period that made concentration difficult._____

3. Methods used to improve performance_____

their students about the impact of their disorder and its treatment on memory.

Self-awareness can go a long way to reducing frustration, and memory improves when frustration is diminished. Use the self-awareness checklist (Box 18) to teach self-awareness.

Also help your student to recognize that memory problems resulting from mental disorder and treatment may mean that what was once learned with ease may now be quite difficult. It is important to help her/him to create realistic goals and to recognize and accept her/his limitations. The self-awareness check-list is likely to show that the student cannot accomplish as much as she/he thinks, but it also shows when progress is being made.

Self-awareness is also gained through discussion with others. Thus students should be encouraged to participate in self-help groups, where they will discover that others face the same memory problems.

Finally, keep a record of the strategies which work best with each student. Make sure that you are not the only one who uses these strategies by teaching your students how to use them too. In this way the student learns, along with literacy skills, the most important skill of all: how to learn.

Chapter Four
PROBLEMS AND STRATEGIES FOR LITERACY COORDINATORS AND INSTRUCTORS

TEACHING adults who are being treated for mental disorders places special demands on literacy coordinators and instructors. During the interviews we asked them to speak about these demands. In this chapter their most common concerns are described and strategies are suggested for minimizing difficulties related to these issues. These can be found in alphabetical order, as listed in Box 19.

Box 19

Problems Described in Chapter Four

Problem	Page
Advocacy	64
Attitudes toward Psychiatric Treatment	69
Class Disruptions	70
Confidentiality	73
Discussing Mental Disorders with Students	76
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Group vs. Individual Teaching Methods	79
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Advocacy

The problem

Sometimes an instructor is approached by a student to act on the student's behalf. This is the role of an advocate. The help that students request most often is that instructors support their efforts to change medications. Instructors are also asked for help with financial problems, disputes with friends and family, abuses by landlords, and difficulties finding and keeping jobs. What should these instructors do when asked to act as their students' advocates for problems such as these? This person believes that being an advocate is not an instructor's responsibility.

> *"A patient will bring a problem to me because he comes for instruction everyday. Students get to know me pretty well over a period of time. So they'll have something they want me to do for them, like help them change their medication. I always refer them back to their primary nurse, or doctor. I'm a teacher and that's it."*

A community nurse says about tutors becoming advocates:

> *"I prefer tutors to be neutral. The emphasis should be on teaching and they should refer students to someone else if they have other problems. Teachers don't need to become advocates."*

This instructor feels somewhat pressured to avoid becoming an advocate.

> *"There's a problem with stepping out of line. People get territorial in hospitals and don't like it if you encourage patients to challenge what they do. You'll get the reputation for being anti-psychiatry and if this happens, you won't get any cooperation."*

Another thinks the class loses its identity as a school if the instructor acts as an advocate.

> *"You notice things that get in the way. But I think it's important to remember that when students are in the class they should see themselves as students so that they don't confuse the role of the teacher with that of an advocate. Also, teachers just don't have the resources and we often find ourselves extended beyond where we want to be."*

A student thinks instructors are not qualified to act as advocates.

> *"I don't think we should be asking them to go to the doctors, although a lot of the guys here do. The teachers may mean well, mind you, but they*

can't do anything and I don't think they know much about it."

An instructor fears giving the wrong advice.

> *"I don't feel I should be her advocate. Other people are better at it. I'm afraid I'll say the wrong thing. It's not a legal fear. I'm afraid I'll say or do something wrong. If I wear too many hats, I'll get frazzled. I don't have the confidence to do that."*

On the other hand, this tutor assumes that literacy and advocacy go hand-in-hand.

> *"I think advocacy is part of my job. If she's having trouble with a landlord, I try to help out. Sometimes we just talk about what she can do. Once I helped her to get her landlord to change a lock on a door."*

So it seems there are many opinions about literacy workers being advocates as well as instructors. The decision rests with the people involved. Some suggestions for acting as an advocate may help instructors to make a decision that is right for them and their students.

Some strategies for the issue of advocacy

RECOGNIZING WHAT IS REALLY NEEDED

The word advocacy may suggest doing more than what is needed. All the student may want is an opportunity to discuss a concern with someone who can listen and offer suggestions.

> *"I don't think you should call it advocacy. To me it means that you listen to issues students bring up and if they ask, suggest some possible solutions. This can make it hard to keep on track, but it's no use working on a lesson if all they want to do is discuss what's come up."*

Good listening skills help this instructor to recognize what he is really being asked to do.

> *"These aren't people just working on their education. Their families may be going through rough situations. They really have a lot going on in addition to school. You can't ignore it. Maybe it's best to say that teaching adults with these difficulties takes a lot of time because there is a lot going on."*
>
> *"How do you get back to teaching reading?"*
>
> *"Actually it's not so difficult. I'm a listener. For me it's gratifying. If a*

student goes on and on and it isn't necessary, I can usually tell and then I suggest that we get back to the lesson. Mostly they just want to talk for a few minutes."

This instructor has created a role somewhere between 'just teaching' and being an advocate. She describes her role as a resource person.

"I get information for them that they need. Sometimes that means writing a letter or making a phone call. If they can do it, fine, but that's not always possible. One chap tried to get some information by phone and they kept putting him on hold. He doesn't have much patience, so I made a call after we discussed it. As for drugs, I get them information about the meds. Some squawked about this, but I spoke to the doctor and he thought nothing was wrong with it. You can see yourself as a resource person. That way you get cooperation and you're useful."

A community nurse describes good teaching as helping students to deal with underlying problems that lead to unnecessary confrontations.

"A lot of the guys who come here don't know much about where they can go for things they need. I mean stuff that is simple for you and me, like how to get a library card or finding stores with good buys. Teachers should teach this and troubleshooting, like going over a lease. Maybe this isn't advocacy, but you'd be surprised how simple issues can become a big deal and cause trouble just because of some misunderstanding. I think teachers should help out on things like this."

One tutor uses a three step strategy to encourage alternatives to direct advocacy.

"First, I discuss the issue with the student and we try to come up with possible actions. We talk about who will do what and it's made clear why I need to take the ball, if that's what we decide. Next, we carry out the plan. If it works, fine. If not, we talk about it again. Sometimes we change our approach. That doesn't always work. This leads to the next step, which is more aggressive, I suppose. We contact a support group, sometimes an advocate in the community, or someone in a local self-help group. They take it from there."

HANDLING REQUESTS FOR CHANGES IN MEDICATIONS

Since this request is so often made by students, it deserves special attention. First, instructors should realize that psychiatrists differ in their willingness to accept suggestions from others about treatment for their patients. Some even find it hard to accept feedback from their patients. Second, instructors should avoid acting on behalf of a student. Instead, they should support the student's effort to discuss therapy with her/his doctor. One psychiatrist suggests helping students prepare a

list of questions to ask during a regular appointment with their doctors.

> *"When patients come into my office there is a lot to discuss. They get nervous and let important issues they wanted to bring up go by. Especially schizophrenics, they get pretty disorganized. To top it off, we can be intimidating without meaning to be. So I think they should be helped to make a list of issues they want to raise and questions to ask. Teachers can help them make it. It doesn't hurt to add the reasons for the changes. For example, 'my teacher says I keep falling asleep in class'. This gives me something to go on. Drowsiness may be a price one has to pay in exchange for other symptoms, but often we can work around it if we know what the problem actually is."*

CONTACTING A TRAINED ADVOCATE

Speaking to a trained advocate can provide excellent information on what might be done in a given situation. An advocate working for a community service program gives four reasons why contacting an advocate may be the best strategy for instructors to use.

1. People cannot advocate from within the system. Advocates need to be free of indirect intimidation. This is especially true for instructors working in institutions like hospitals and prisons.

2. You must recognize the difference between cause advocacy and case advocacy. The purpose of cause advocacy is to change the system. Case advocacy is dealing with an individual's problems. Failing to keep this difference in mind can create confusion about what you are trying to achieve.

3. The advocate's first rule is to talk to the person needing the advocate's help and then to take only those actions approved beforehand by her/him.

4. People have the right to fail and succeed. You can provide support and advice but an advocate does not take the issue over. The decisions and the outcome of those decisions belong to the person.

BEING AN ADVOCATE

If an instructor or literacy coordinator decides to take on the additional role as advocate, a community advocate suggests ten points to be followed. These are described in Box 20. Also see page 73 and read about confidentiality. This is an important issue related to advocacy.

Box 20

Ten Points On How You Can Help Students to Contact Advocates and Other Resources

1. Listen to students carefully. Encourage them to tell the whole story. After they finish, summarize to be sure you understand what was said. Take notes.

2. Once a story is clear, ask students what they want you to do. Some may just want to talk about it. Some have good reasons for not wanting to take action and you must respect their wishes.

3. Don't offer advice off the top of your head or based on what you overheard 'someone' say. If you and the student decide that you can help, be certain that you have the student's permission to do so, and keep her/him informed of each step you take. If at any point you are asked to stop, discuss this decision but respect what the student decides.

4. Don't do more than is requested. You may feel good attacking the system, but you aren't the one who will experience the consequences. Your task is to support the student's decisions and provide reliable information.

5. Recognize your own limitations. Don't promise to do something and then fail to do it. Use good judgement when you report that someone will be contacting the student or sending information. If you suspect that the person won't fulfil her/his obligation, you should make your suspicion known to the student.

6. Students should play active roles in clarifying a problem, finding an advocate, or seeking information. If someone you contacted on behalf of the student wishes to speak with you, arrange to have the meeting when the student is present. Your role is to support the student not to take over.

7. Remember that a student's frustration and victimization may be the result of an inability to communicate in an acceptable manner. Teach the student how to be polite but firm. Help the student write an effective letter of appeal for action by being brief and by stating the facts.

8. Students may be frightened about taking an issue to a higher authority. Frequently they are unaware that a senior position exists which can overrule decisions of a line staff. Provide this information, and if requested to do so, help prepare whatever material is needed to appeal to the higher authority.

9. If you are responsible to someone in a management position (e.g. a project coordinator), keep this person informed. Be sure to tell the student that this is being done. If you are advised by a person in a senior position to stop, you must inform the student that this has taken place.

10. Whenever possible, encourage people affected by bad decisions or unfair practices to get together. Mutual support and common action help to create strength, overcome feelings of isolation, and reduce the possibility that an individual's problem will be dismissed as 'a mistake.'

Attitudes toward Psychiatric Treatment

The problem

There is a point of view which challenges the reality of mental disorders and sees psychiatric treatment as forms of oppressive control. This perspective, sometimes called the anti-psychiatry movement, has gained support from studies by sociologists, patients, and psychiatrists. People who accept that mental disorder exists may question the ability of mental health workers to recognize it and to do anything about it. A controversial aspect of mental disorders is their treatment. Drug therapy is accused of masking symptoms, making it easier for staff to suppress patients' anger over mistreatment, and creating more health problems than it solves. Electro-shock therapy is especially controversial. Some people accept the view that mental disorders are diseases which should be cured medically; others see mental disorders as serious problems but support only non-medical therapies (e.g. group therapy).

Strategies for instructors who share this point of view

Instructors cannot avoid having opinions about these issues. They must ask themselves how their opinions influence their relationships with learners. A program coordinator offers this advice.

> *"You'll question the use of drugs and psychiatry. I do. But it's a different thing to turn those questions into practice when it comes to working with a student. If you're adamant about the negative effects of medications and psychiatry, you'd be better off not working in this field. If you want to change the system, that's great, but don't do it as a tutor. The student could suffer for your mistakes."*

An instructor working in a mental hospital provides this advice.

> *"If you take an anti-psychiatric position, you won't get cooperation from the staff working with the student. So you're not going to be of much help to him. And I think it is dangerous. I don't know of any teacher who is in a position to take the responsibility of advising a student not to take drugs. You have to ask yourself if you're in a position to offer reasonable alternatives. Are you aware of the consequences for what you are saying?"*

Students, instructors, and psychiatrists support the point of view that those with strong anti-psychiatric attitudes should avoid working with adults who are being treated by psychiatrists for mental disorders. A psychiatrist suggests that it is not a matter of dismissing the alternatives. If the student is interested, the instructor should discuss the issues and encourage the student to become well informed.

Instructors can help students to discuss treatment with their doctors, to seek another doctor's opinion, and to visit therapists who are not doctors and ask for advice. If a self-help group is nearby, the student can be encouraged to go to the group for suggestions and support. That is exactly what this instructor did.

> *"My student was having difficulties with her medication, so I suggested preparing a list of her difficulties and presenting them to her doctor when she saw him. I suggested that if he didn't come through, she should see another doctor for a second opinion. Then we worked on some questions. She was nervous about it, but she did it. I think you can do a lot more this way than by ignoring problems or telling students that you don't like drugs or doctors."*

A former patient who now works with a self-help group encourages people to listen to other points of view.

> *"I don't tell anyone to stop seeing a doctor. I don't tell anybody to do anything. We've had plenty of being told what to do, when to do it, without ever being told why. Forget being asked our opinion. So I don't tell them what to do, but I do let them know that there are alternatives and I give them information about them. We discuss it. Group support is important. The person makes up his own mind, and we try to support the decision."*

The Resource Guide at the back of the handbook includes a list of self-help support groups and other materials which literacy coordinators and instructors can use to educate themselves and students about mental disorders and treatment issues.

Class Disruptions

The problem

Instructors and program coordinators express concerns about learners' disruptive behaviours. As adult educators they do not expect to have to deal with 'misbehaviour'. This concern is often difficult to express, because talking about it makes instructors feel unsympathetic. This makes it even more important to discuss it here.

An example is the man who gets up from his seat and begins pacing the room or talking to himself. This behaviour distracts those who are trying to study. If the instructor shows too much tolerance for his behaviour, others get angry and either complain or leave the class. This difficulty is illustrated further by this instructor's account.

> *"In the midst of someone talking to me, she'll start talking, and loud. Sometimes it's related to what was being said but mostly it's completely unrelated. I also had a fellow here last year that just got up and stomped*

out of the class. Then he'd come back in and make a bit of a speech and walk around the room. Then out he'd go again."

Disruptive behaviour may involve sexist jokes, sexual harassment, and racial slurs. This instructor lost her patience and left the class.

"I'd try to make some allowances for him, but it got to be pretty insulting. Furthermore, the women in the room would become offended and they'd challenge him. That usually made things worse. Once I just walked out of the room myself. I couldn't take his jokes or the argument that started up with the others."

Characteristics of schizophrenia and manic-depressive disorders may be behind some of these disruptive behaviours, although problems caused by sexist and racist comments are by no means restricted to situations where instructors work with students being treated for mental disorders. Hallucinations may lead to talking out loud. Delusions also create disruptive behaviour. When a person is manic, she/he may talk excessively and move around the class picking-up on things happening here and there. For example:

"When he did well on a math problem he'd start telling me how wonderful I was as a teacher. He'd cry and even ask to kiss my hand as a token of his appreciation. And if he didn't get a problem right, he'd start talking a mile-a-minute about how he couldn't handle such hard problems and would I please give him something easier to do. He'd beg. It was pretty upsetting for me and the others in the class."

These disruptions can trigger further trouble in classes where there are students being treated for schizophrenia. Too much emotional excitement can trigger delusions. These people require structure and a calm, relaxed environment in which to study. Emotional outbursts, loud talking, and physical movements are contrary to what they need. Disruptions cause problems in a 'normal' classroom. In a class with students being treated for schizophrenic disorders, the problem is magnified.

Disruptive behaviour is a serious concern. It creates frustrations for instructors and learners. In their desire to be understanding everyone tries to be more tolerant, but tolerance has its limits. Strategies are needed for dealing with this difficulty. To learn about disruptive behaviours related to delusions, thought disorders, and hallucinations, turn to these topics in Chapters One and Five. Some general recommendations follow.

Strategies for controlling disruptive behaviour

CONFRONT DISRUPTION WITH CALMNESS AND FIRMNESS

Disruptive behaviour is often triggered by emotional excitement. When this occurs, the instructor should avoid the impression that she/he is ignoring the

situation and instead should try firmly to establish a calm situation.

> *"You must have the option of asking them to leave. If you ask students to leave, usually they will. I've never had a problem with that. You keep that in mind. But this isn't necessary in most cases if you recognize what the person is saying and coach them back to their work. Create something to focus on, like sitting down and reading. Stick to that, trying all the time to sooth the situation. Anger only makes it worse."*

This instructor emphasized the value of allowing other students to help control the situation.

> *"The old timers are familiar with these situations; they don't panic over them. Some will get angry, and with some people that works. But from my experience only when the anger comes from another student does it help. Others will just ignore the outburst, waiting for it to pass. I had one student who could calm this really disruptive fellow. He'd yell and shout some pretty nasty things. She was great. She'd say, 'Forget it, get back to work. Let's go back to work. You aren't going to do anything.' She'd just keep this up and he'd calm down. Meanwhile the others didn't get upset because they saw she was trying to do something."*

TEACH SOCIAL SKILLS

The goal of social skills training is to develop social competence by improving the person's ability to express her/his thoughts and feelings in a way that enhances interpersonal relationships. Social skills includes learning how to avoid conflict.

Literacy programs do not need to become social skills programs, but including some of the process of social skills training into lessons may improve everyone's ability to deal with disruptive behaviour. Learners can be taught to handle problems of increasing difficulty (e.g. responding to interruptions and responding to criticism). Social skills training is used with families when a person being treated for a severe disorder is living at home. The goal of this training is to develop effective ways for 'cooling' the emotional climate of the household. This approach may be used in adult education settings with equal effectiveness.

If literacy workers are not trained to teach some social skills, a coordinator should invite experienced social skills trainers to give a workshop on basic methods and goals.

Increase your awareness of your 'coping styles'. Individuals develop coping strategies for dealing with disruptive behaviour. Box 21 describes these styles. By becoming aware of how you cope with disruptiveness, you can begin to work toward developing alternative styles. If the goal for reducing disruptions is to create less emotional excitement, obviously you want to use coping styles which have a calming effect on the person and those around her/him.

Learning alternative coping styles takes effort. Program coordinators might want to organize a workshop in which instructors can practice different coping styles using role playing techniques.

Box 21

Coping Styles

Alternate Ways of Responding to Greg's Disruptive Behaviour

Greg is working on some math problems. Without a hint that something is upsetting him, he gets up from his chair and starts pacing around the room. He wanders toward the woman at the photocopy machine and pesters her with some jokes. Then he walks over to the instructor and interrupts her. He complains about the math being too hard. Two men working on a project don't like what is happening and they excuse themselves to go upstairs to the library. What does the instructor do?

Here are five coping styles which anyone is likely to see people use when faced with Greg's disruptive behaviour. Becoming aware of these styles may help you to develop alternative approaches for coping with disruptions.

Coercion
"I'd tell him off. I'd let him know how stupid he's being. I'd say to him, 'Greg shut-up and let us work. You always cause trouble. Either shut up or get lost!'"

Avoidance
"I know he acts this way, so I just leave him alone. You can't convince him of a thing when he gets like this."

Ignore
"I ask him if he's alright. Then I let it be. He's just going through one of his things. It's just part of his illness."

Collusion
"I go along with him for a while. What's the harm? I'll tell him that this math is pretty stupid sometimes. They never give clear directions. A bunch of dopes write this stuff. I just kid him along."

Constructive
"I try to get him to get back to his work. If that doesn't work I'll suggest something to change the pace. I'll tell him that he can't act that way because it upsets everybody. You get him off what's bothering him and focus on something productive."

Adapted from Birchwood and Cochrane, 1990:.864.

Confidentiality

The problem

When students approach instructors seeking advice, they may begin by asking the instructor to keep what is said 'just between us.' Maybe the person has suicidal thoughts and she/he does not know if the doctor should be told because there is a risk of her/his being sent back to the hospital. Or the issue may be embarrassing but not harmful to

someone else. This tutor tells about being asked to keep information confidential.

> *"He came in looking messy. He really smelled and I asked what was happening. He said some stuff was going on which he'd like to talk about if 'I could keep the lid on.' So I said I would, which was a big mistake because it turned out that he'd been kicked out of his rooming house and had spent a week on the street. He wasn't taking his meds, and he was getting into scraps. When I told him that it seemed like he should see his community nurse, he got pretty upset."*

> *"What did you do?"*

> *"I kept my word. He didn't come back for about six months. Cops picked him up and sent him to the hospital."*

One psychiatrist warned that things held in confidence which may seem very serious might actually be fantasies.

> *"Fantasies are common enough with some disorders. People fall in love, exaggerate what someone is saying, and create really complicated stories that sound perfectly real. They'll believe them too. So you're all caught-up in a fantasy which you can't check because you're keeping it a secret. You must avoid this."*

Another situation involved a student who asked a program coordinator to act as an advocate. After the coordinator agreed, some issues were mentioned which the coordinator thought should be told to a social worker. When the coordinator said this, the student got angry because he assumed they were speaking in confidence.

A community nurse reminded us that some people being treated for mental disorders are in the community on passes issued by prison authorities. If these people violate the condition of their passes, they are violating the law. Instructors must not cooperate with this and can only avoid doing so by refusing to keep secrets.

A related concern is when a student's friend, employer, or family member asks for information. Here is an example:

> *"Her boyfriend - I think that was the arrangement - kept calling to ask if she was coming to the library and if she was doing well. Usually, probably always now that I think of it, he'd end up asking that I not mention his calls to her. I'd agree, but I could never tell if he was sincerely interested in her progress. In fact, I didn't really know if he was her boyfriend."*

Strategies for dealing with information spoken in confidence

RESPECTING THE RIGHT OF CONFIDENTIALITY

If the instructor contacted by the 'boyfriend' had been working in a mental

hospital, she/he would have been under a legal obligation to protect the confidentiality of information relating to her/his student. This is true for all mental health workers, including doctors. Instructors and program coordinators are advised to adopt this principle of confidentiality as a matter of good practice. For most situations involving confidentiality, the policy of this community program seems like sound advice.

> *"We don't give out any information about our students to anyone unless the student is there to approve."*

AVOIDING SECRETS

Keeping secrets creates a potentially dangerous situation. Rarely is it necessary to do so. Students will often discuss a private matter without sworn secrecy. This instructor makes it clear to students that he is pleased to listen and offer advice, but he refuses to listen in confidence.

> *"This is tricky. It usually involves things raised in confidence. What I say when it first comes up is that I won't keep secrets. I can't because I'm not in a position to do so. I make sure I tell them this."*

MAKING AN AGREEMENT

Situations may arise when an instructor feels the need to speak to the student's doctor or community nurse. Should she/he speak to the mental health worker? One instructor told about a student who raised issues during almost every session and wanted to speak in confidence. It became annoying. What was the instructor to do? A psychiatrist advised having a clear policy agreed upon between the student and the instructor.

> *"Get permission beforehand from the patient to talk to the community nurse or whomever if real worries come up. Just ask for this permission. If you can't get it, then don't pass on the information. At the same time, resist being put in the position of keeping secrets. It creates serious problems. The bottom line is that you must be free to speak to someone if you honestly feel the need is there."*

A program coordinator explained what she does.

> *"I tell each student that I don't keep any secrets. If a tutor is told by a student that he's stopped taking meds - that's a good example, we'll report it to the doctor. This is here at the hospital. In the community, the community nurse should be told."*

An experienced instructor helped to put it in perspective.

> *"I explain the situation and they understand. Actually it's not a big deal if you keep it all open. They usually accept this and that's the end of it."*

Discussing Mental Disorders with Students

The problem

Most literacy coordinators and instructors do not know that a student is being treated for a mental disorder. Some prefer not to know, believing that this will prejudice the student-instructor relationship. Others believe that discussing these matters is prying into students' private lives. Avoiding self-fulfilling prophesies and the violation of privacy are important considerations; however, it is equally important to avoid misunderstandings. For instance:

> *"She wouldn't come to the centre on time or she'd just not show up. When I'd ask her about it she'd say she wasn't feeling well, and I'd leave it at that. But I figured something else was going on, like maybe drugs or something like that."*
>
> *"Did you ask her?"*
>
> *"No, I didn't want to pry into private business. Her attendance improved for a while; then I had to stop tutoring and I haven't worked with her since."*

In this case the student was taking antipsychotic drugs which made her sleepy in the afternoon. Had the instructor known this, together they might have made some changes to reduce the problem caused by the side effect of the drug. Several students we spoke to believed that instructors should ask students if a health problem is interfering with their ability to study. A student illustrated the problem this way.

> *"I don't look like I have a mental illness. Even nurses on the ward say to me, 'Gee, you don't look like you belong here.' People have this image of what you're supposed to look like and I don't fit it."*
>
> *"Isn't that an advantage?"*
>
> *"Not really. If I try to tell them that I have this problem and may need some help, they don't seem to listen. I think they just look at me and don't want to hear what I'm telling them."*

Students want their instructors to ask. Deciding whether or not a health problem should be discussed should be left to the student and honoured by the instructor. So it is clear that we should ask about students' health problems, but how? How should the instructor go about finding out if a student is being treated for a mental disorder? We asked students, instructors, and psychiatrists this question.

Strategies for sharing information about disorders and treatment

BE PATIENT

With some students it will be difficult to ask them about health problems. Some will not speak about this subject for any number of reasons, and this must be respected. People who have spent a long time in mental hospitals have experienced a great deal of close observation and they may wish to avoid doing anything which brings them under more scrutiny. Also, persons treated for schizophrenia are often very private. It may take a long time to build the trust needed before a student feels comfortable about sharing important information. A psychiatrist provides this advice.

> *"Teachers should ask. Don't push, but it's worth asking. You can also get a sense of the gravity of the illness and an idea of how it affects the person's life."*

Another psychiatrist noted:

> *"If the patient knows, he'll usually tell you. Sometimes he'll not have it right. He may say that he's being treated for his anger when the illness is diagnosed as schizophrenia. If you ask about his medications, you'll have a pretty good clue about the severity of the disorder. These problems can be worked out. The first important thing to do is to ask when you suspect that something is interfering with the way the student studies and comes to class."*

As well as obtaining information about the disorder and treatment, instructors should find out about the student's community support and her/his knowledge about her/his disorder and medications, especially significant side effects. This is an ideal time to find out who to contact if the need arises. The student may not want you to contact anyone without permission. You and your student can work these issues out together. The important thing is for you and the student to become comfortable with discussing these issues.

Students generally support these recommendations. One said that the instructor has a right to know about the student's health problems and that the instructor should speak to the student. As well this student thinks that the instructor, nurse, and family members should know each other. A second student said:

> *"Sure, they should be asking. If you have some problem or a problem arises, the teacher may have to contact the hospital. I don't think you can take this stuff [medications] and go to school and not let the teacher know about what it does and how it works. "*

Another said:

> *"Don't beat around the bush. It's important to be direct. You need to*

know. If you don't, how are you going to deal with the person's bad days? You won't know how to set the right pace. You'll be out of touch. I'll tell you the truth. I think teachers who don't ask are afraid to ask. They've got to though, if they want to do a good job."

Fear of Danger

The problem

The media often depict people with mental disorders as violent and dangerous. This is an unfortunate stereotype. For instance, according to a study by the Association on Handicapped Student Service Programs in Postsecondary Education, people treated for mental disorders are no more likely to be arrested for violent crimes than are people in the general population. Instructors working with students in institutional settings report that violent outbursts are very rare. One person who has been teaching adults with psychiatric disorders for nearly ten years could remember only two minor incidents. Describing one, he said:

"It was my fault, really. I made this rude remark that was really out of line and she punched me. It hurt but it didn't amount to much. I was really out of line."

A nurse working with mentally disordered offenders living in the community assured us that his patients have not posed a problem at work or in school programs. He went on to stress the importance of correcting the inaccuracy of the media when it comes to the dangerousness of people with mental disorders. However, these fears are not so easily set aside, and so we asked students with histories of violence toward themselves or others to tell us what to look for and how to act.

Strategies for identifying signs of danger and knowing how to respond

'DON'T PUSH'

Psychiatrists tell us that the important signs of danger to look for are changes in behaviour. The student may start showing signs of poor hygiene, tension, irritability, and being withdrawn. People with psychotic disorders may become suspicious. When these changes occur the instructor need not become fearful but should begin to take reasonable precautions. Talk to the student. Be supportive but 'don't push'. A student described what happens to her when she becomes dangerous and offered this suggestion for instructors.

"I'd get frustrated because I couldn't understand what the teacher was telling me to do. So I think the teachers should watch out for frustration."

"What should the teacher do?"

"Sit down and talk. Maybe take a break for a while. That usually did it for me."

WORK IN A PUBLIC SPACE

If you have some concerns when you begin working with a student, you may want to work with the student in public places (e.g. the library or the office of the literacy program). If you are working in a room, place yourself close to the door. If students want to leave, let them go. Letting the student leave is a responsible thing to do. If you think someone may get hurt, contact the student's doctor or community nurse.

DEALING WITH HALLUCINATIONS

People treated for schizophrenic disorders may hear voices which tell them to do things. These hallucinations may lead to aggressive outbursts. The problem is not likely to occur suddenly. Over a period of several weeks the student becomes withdrawn and offers bizarre remarks. If this happens, speak to the student about the behaviour. Suggest that she/he see a doctor. An instructor with years of experience made this suggestion.

"Yes, I talk to the students. Usually I ask them if they are mad at me for something I did. In most cases they'll say no. Then I ask if they want to talk about it. Usually they don't want to, but just helping them to realize that they aren't mad at me does the trick. Then I step back while they work alone or we stop and do something to relax."

Group vs. Individual Teaching Methods

The problem

While one-to-one teaching is the most common teaching method used, group learning is often favoured when students are in a classroom setting. Group work is increasingly popular because literacy is more than learning to read and write. It includes improving oral communication and cooperative work skills. Literacy is linked to the ability to take an active role in community affairs. This view of literacy requires group activity. Thus small group learning becomes an essential part of instruction.

However, while group learning may be preferred for these reasons, literacy workers expressed concerns about its value with adults being treated for mental disorders. As one instructor began to comment on this problem, a student came over to tell us why individualized instruction is essential for her.

"I have to have someone working with me constantly. When you're in a class with 24 other students, you don't get that help and that's hard. I can

do math on my own and some [subjects] with others, but reading and spelling I have to sit down with a teacher or I can't concentrate."

She went on to say that groups create embarrassing situations.

"I can't keep up. So I try and I rush, but then it's just a mess. The work is full of mistakes. I don't want to keep asking the teacher to come to help me because I end up hogging her time; then everyone in class notices and that is really embarrassing. During coffee break, you don't want to talk to the other students because they may think you hog the teacher's time."

When her instructor discussed group and one-to-one teaching, she emphasized that anything but individualized instruction has been impossible.

"I have to work individually because I have a classroom full of students all working in different subjects or at different levels. Right now there are students working in reading, math, and social studies. The two fellows in reading are far apart. We do some groups when people are closer together, but it's more reading together than group participation."

In fact students come and go from the class and the hospital schedule makes it difficult to have groups working together for more than very short periods of time. Poor facilities also create limits on teaching methods, as this tutor observes.

"I'd like to do some group work, maybe in reading, but you can't work with more than three students at a time in here. Often students are called back to their units for one thing or another and so I have to use individual instruction or the lessons wouldn't work."

In addition to schedule conflicts, mixed groups, and limited facilities, characteristics of disorders seem to have some impact on students' abilities to work in groups. In the case of schizophrenia, psychiatrists differ over the effectiveness of group work. Those being treated for schizophrenia may appear timid and unwilling to trust strangers or even long term acquaintances. A delusion, hallucination, or thought disorder may create an awkward situation which disrupts the group work, resulting in hostility toward the student. This psychiatrist has seen some remarkable work done in group therapy with people being treated for schizophrenia. However, she thinks one-to-one teaching is still preferable.

"Lately, I've been really amazed by the results I've seen with schizophrenic patients in group therapy. So I suppose that group teaching could be used cautiously. But I still think teachers would have more success with one-to-one teaching because it helps to keep down the distractions and it provides more structure. With someone being treated for other disorders, group teaching would be fine, although you may have some problems with someone who is manic."

Some anxiety disorders (e.g. social phobia) create serious problems for group work. In fact, fear of working in a group setting is often enough to keep an adult away from a literacy program. When this is a difficulty, one-to-one teaching provides the adult with a chance to learn without struggling to overcome his/her fears of social situations.

Those who work with students suffering from head injuries favour one-to-one teaching and a 'buddy system'. The head injured student is likely to have wide discrepancies in ability, inconsistent performance, problems with structuring information, and exaggerated behaviours which distract other learners. Common problems such as lack of insight and an inability to plan and initiate activities require clearly defined and structured tasks, an environment free of distractions, and on-going feedback and reassurances. These needs may be difficult to meet in a group setting. However, instructors have made good use of a buddy system. The buddy can adjust the pace and structure of a task to meet the learner's needs, while at the same time providing peer support.

Strategies for using small group instruction

DRAWING ON GROUP EXPERIENCE

Several instructors mentioned that students who participate in group therapy gain skills for group work. One group therapy program which resembles classroom activity is the social skills training group. The primary goal of social skills training is to improve a person's ability to interact effectively with others. Emphasis is placed on teaching skills for finding and keeping a job, interacting with people in public places, and resolving conflicts with friends and family. A ten step approach used in one program provides guidelines for how group learning may be used with people who may need more structure and less distraction than other students. The ten steps are:

1. Make the purpose of learning clear.
2. Divide the learning task into steps.
3. Discuss the steps with group members.
4. Model the steps and the outcome.
5. Ask a student to go through the steps as a second model.
6. Take the group through the steps, possibly using sub-groups or a 'buddy system'.
7. Provide on-going and follow-up feedback.
8. Provide additional opportunity to rehearse the skill.
9. Provide more feedback.
10. Practice the skill during the next and subsequent session for additional practice and feedback.

STRUCTURING GROUP WORK

Especially in the case of schizophrenia, structure and reduced interruptions are very important. For this reason individualized teaching or 'buddy systems' are preferred to group instruction. However, group work can be used provided that the groups are well structured. This tutor, who assists an instructor in a hospital setting, explains how he

uses group work with long-term patients being treated for schizophrenia.

> *"I like to have some group work because it makes the class more friendly and social. But the students don't do well in group discussions - like a social studies debate. I use a small reading group. Four of us sit around a table and read in turn. After each person finishes I ask a comprehension question. Usually there is a quick answer and we go on to the next person. Sometimes we'll spend more time discussing it or someone tells a bit of a story."*

Instructor or Therapist

The problem

There is often a fine line between the role of a therapist and that of an instructor. Making the distinction is something both the student and the instructor may have to work on, but work on it they must. People with experience working with students strongly advise that instructors should be instructors. A program coordinator says:

> *"It seems to me they have therapists. I don't think we are giving them what they came for if we become therapists. The students come here for an education not treatment. Sometimes the line may be pretty hard to draw between the two, especially when the student isn't feeling well. But you should try."*

An instructor puts it this way:

> *"The patient has a therapist and the therapist handles the therapy. I'm the teacher and I teach. And I try to stay out of the other because if I got into it, I could be working against the therapist. I'd rather work with the therapist in a collaborative way. The best way to do that is to be as much of a teacher as possible."*

Strategies for avoiding the role of a therapist

AVOID TURNING CLASS ACTIVITIES INTO 'GROUP THERAPY'

Students in hospital settings may attend therapy groups. When subjects discussed in the classroom overlap those raised in these groups, the instructor must avoid turning class discussion into a therapy session. The theme of a story or play may pose the same problem. A student explains how his instructor handles this situation.

> *"We'll start talking about our problems when something in class is like*

what we talk about on the unit. But he tells us to 'take a break' from the psychology stuff and talk about the story without turning it into a discussion about us. We laugh about it. You can't avoid it all the way, but he keeps it down pretty good."

KEEP YOUR DISTANCE

Some instructors working in mental hospitals participate in the meetings where patient progress is discussed (i.e. case conferences). Others attend therapy groups as part of the treatment staff. This involvement is supported with the belief that by participating in therapy activities the instructor keeps in touch with her/his students' needs. There are other instructors who avoid this type of participation because they do not want to be seen as therapists. These instructors recommend keeping some distance from therapy activities as one way to avoid slipping into the therapist role. It is obvious that others do not agree with this strategy, but it is one that is recommended by several instructors.

Trusting Students

The problem

A common stereotype is that people being treated for disorders are devious and untrustworthy. It may be that when a person is confined in a mental health or prison for some time, she/he becomes very cautious about sharing information. A common characteristic of schizophrenia seems to be a low level of trust, even a certain timidity. Therefore, a student may withhold information from an instructor. Or a person may twist the truth to avoid unpleasant consequences caused by misunderstanding (if not outright prejudice). In many cases the person may not know the answer and so creates one to avoid embarrassment. A psychiatrist puts it this way.

"If patients know their diagnosis and they trust you, they'll usually tell the truth. Many don't know. Either they weren't ever told or they can't remember or get it right. Some won't know the name of their medications. That's very common. So they may make one up or call it by its side effect instead of by its real name - like 'I take a sedative' when they're taking an antipsychotic."

An instructor who does assessments asks students about their school history. Overall, her experience suggests that adults can be trusted to give accurate information. Misinformation is almost always the result of ignorance. Not knowing the answer and feeling that they should, students often make guesses. Sometimes they have become so accustomed to answering with a certain response that it becomes a habit.

"That's what happens most. They don't know what grade they were in so they make a guess and that's what they tell people when they are asked. I trust them to tell the truth about their school progress. Sometimes we check against Department of Education records. If there is a difference between the record and what they said at the interview, usually they're surprised by the report, and you can see why they thought they had finished one grade when they had only completed something less."

Instructors are concerned about honesty. The best advice we received is to trust the person unless she/he gives you a concrete reason for not doing so.

Using Controversial Materials

The problem

Instructors raised the problem of using controversial topics when we discussed the need for high interest reading material for adults. For instance, it is now popular to produce and use materials which focus on social issues related to student experiences (e.g. wife abuse). Is it advisable to use these materials with students being treated for mental disorders?

As a typical case, an instructor showed videos on current issues as a regular part of his program. His purpose was to increase student awareness about current affairs since they did not read about and discuss these topics with more than the superficial information taken from T.V. news. Most often the lessons went well, but occasionally and unexpectedly a problem like this would appear.

"I wouldn't show anything with too much violence. But you don't always know when something is going to be controversial. We started to see this science video about evolution and a fellow said, 'I don't want to see this.' And he started talking on and on about it. It started a delusion, I think that's what they [the staff] called it. I didn't argue. Some people are very set in their ways. Then you hit a subject which you figure is controversial, like when the Gulf War was on. I didn't support it, and that came up. The students didn't mind. We had a really worthwhile talk about it. So you don't always know what will happen."

When this concern was raised with students and instructors, responses were mixed. Most thought that controversial material could cause unforeseen problems, especially when the person is being treated for schizophrenia. In fact, other disorders were never mentioned in relation to this issue. An instructor working in a mental hospital said:

"There's a fad to use controversial material: like stories about

alcoholism. I don't think these guys need to read about things they experience all the time. If they wanted to discuss it, that's one thing. It's another for me to bring it up in the reading material. It's dynamite with a schizophrenic. It can set them off like a time bomb. Controversy is an overload. You're likely to trigger a delusion. In one case when I was showing a film, students just started to walk out. One fellow was pacing back and forth in the classroom."

A student made this observation about controversial materials.

"It goes against the grain. It creates anger. It's not a joke like some people think. And when the teacher leaves, we hang around and still discuss it. Some don't want to and go off to watch T.V., but the occasional guy will keep talking about it. That gets you mad."

A student, who also tutors people in her class, said:

"They don't like controversial materials. People with schizophrenia aren't very flexible. They stick to what they said at the beginning. They're not too easy going. You'll end up with a confrontation. People know what they believe in and you'll just end up with no debates."

A student who overheard our discussion added:

"It depends on the student. I don't mind at times but at other times I do. It depends. It's tricky. I think it can help to promote tolerance."

A learner at a community literacy program is also concerned about making generalizations.

"It depends on the student. You can grow by reading controversial books but it depends on your illness. You have to be able to talk about it. I don't think I'd show people a controversial movie and just end it there. You have to discuss it. Some can't do that."

Strategies to reduce problems related to the use of controversial materials

CHOOSING INTERESTING RATHER THAN CONTROVERSIAL MATERIALS

Studies which show that adults treated for schizophrenia react to 'high levels of arousal' shed some light on this problem. People being treated for schizophrenia do best in an environment where the level of expressed emotion is moderate.

Arousal level is seen to be an important factor in determining the individual's efficiency in performance. At low levels of arousal...the

individual is likely to be inattentive and easily distracted. Very high levels of arousal involve a state of excessive tension and anxiety and performance consequently suffers (Johnston and Spratt, 1987: 310).

Those working with people treated for head injury and manic-depression made observations similar to this. And while one might assume that a person treated for depression would benefit from the stimulation of controversy, this instructor noticed the opposite effect.

> *"He's been at the hospital a while for major depression. When he reads about social problems he becomes really fatalistic and starts talking about 'why bother?' and 'it's no use, anyway'. So I keep away from this stuff, if I can."*

The strategy implied by these comments is to use creative, interesting materials but avoid subject matter which is likely to create tension, or to remind students of experiences which might cause them to express a great deal of emotion. Since this cannot always be avoided, this instructor's suggestion is useful.

> *"I don't want to avoid discussing issues. But what I find works well is using fiction. A story might remind someone of a painful experience and then the tension can get pretty high, but it's a lot easier to get things quieted down a bit if I can say, 'Well, this is just a story.' That doesn't always do it, but using fiction seems to give you more room than discussing something that really happened just down the block."*

This student would probably agree.

> *"Schizophrenics are creative. If the books are too bland then they get bored. The books don't have to be controversial not to be bland. I think they should be interesting and important. Appealing, that's what. They can be appealing without being controversial."*

CHANGING MATERIALS

You cannot always predict whether materials will create problems, and no one wants to use dry, dull readings. To avoid becoming overly cautious, use materials which may encourage discussion, but be prepared to change topics if you discover they are too upsetting. As this instructor put it, you can always turn the film off.

> *"I didn't realize I could do that. They started walking out and I just kept the film going until they all left. Then I realized, we could just stop it. You treat it like a delusion. You don't argue or try to justify what you did. Just turn it off, apologize for causing people to get upset without making a big deal of it, and focus on another task until calm is more or less restored."*

Exciting materials are being published. Avoiding these materials out of fear that

they will create anxiety among students is not the solution. Instructors do not want to become censors. The best solution seems to be flexibility and sensitivity. By drawing on his experience watching T.V., this student seems to summarize what others said.

> *"Someone on the ward turns on a T.V. program. I might get upset because it brings up some pretty bad memories. I'll start to cry or something. But it's no problem because if they see I'm upset either they'll turn to another channel or I'll go do something else until it's over. The only thing about a classroom is that you can't go some place else. If you could without the teacher making a big deal of it, that would solve the problem."*

Working with Mental Health Workers

The problem

'I have to battle on.' is how one instructor reports her experience teaching in a hospital. Another instructor put it this way:

> *"We're apart from everyone. We get some cooperation, but it's an after-thought. We have to ask for everything. The school just isn't a regular around here, not like O.T. or the social workers. We don't have groups. See, it's just outside and you have to struggle almost everyday to keep your foot in the door."*

For this student, staff treat his class work as the last thing to consider.

> *"They're lots of programs for us to attend: O.T., psychotherapy, Rec. time. You see the doctor once a week, and the nurses start new groups. If my school interferes with a new program or something O.T. wants, the class comes last. I guess they tell the teacher I'm not coming, but I think lots of times she doesn't hear about it because when I come back, she doesn't know why I missed class."*

In a prison hospital, security takes priority over class needs. Guards enter a class to count prisoners, voices constantly come over the loudspeaker, and if anyone in the institution wants to see a student, the student must leave right away. Being in other programs is reason enough for not coming to school, but being in school is never sufficient reason for not attending some other program.

'Dumping' is another indication of poor school relationships with mental health workers. Dumping means that people are sent to the school simply to get them off the unit for awhile. This is how one instructor describes it:

> *"They look at the other programs that are available - like O.T. or some*

group work - and they say, 'He won't gain anything there.' They still want him off the ward because that's when the nurses have a meeting. So where does he go, to school. He just sits there because he's so sleepy that he can't work. They could just let him sleep. Now I send him back when this is tried. But it took a while to stop it. They'll dump someone in school to get them off the wards."

Another concern is the failure of ward staff to make proper arrangements for sending students to class. In one hospital nurses take students to the school, but when the time comes this task is frequently overlooked because the nurses are busy doing other things. Students wait to leave the ward and arrive to class late. In another hospital the instructor goes to the ward to escort students to his class. This cuts into class time, but that is not the only problem.

"Absolutely every time I come to the ward, no one is ready to go. When I come in, the nurses start going around to tell students it's class time. So I have to wait. I swear its like a 'round-up'. If the nurses are talking, I have to wait until they're finished before they start calling my students. We never get to class before 2:15. That leaves about 35 minutes for class. I hate that part of working here."

Although instructors work with patients, mental health workers do not think of them as part of treatment. This has its advantages because it prevents teaching from becoming therapy. However, this is a disadvantage when instructors are not informed about their students' disorders, the drugs they are taking, and how possible side effects may affect school performance. A tutor speaks about this.

"I'm not invited to the case conferences. A nurse is supposed to pass on information, but it never seems to happen. I suppose if I asked I might get information. But no one takes the time to explain anything. I worked here for three years and only toward the end did the women in charge of nursing education ask if we knew anything about the meds and basic first aid. It seems it was required of the staff, but no one bothered to see if a teacher knew anything."

A common characteristic of hospitals is an overabundance of therapy programs. There is often competition among different therapists for patients to participate in these programs. Without patients in their therapy sessions, it is difficult to justify their existence. Schools can get caught up in this struggle. As outsiders, school personnel often lose 'the battle'. This creates real problems for programming, as this instructor observed.

"Programming is very difficult, like finding a suitable time for each person to come here. I need the right mix of people or I can't give each of them the individual attention they need. But some blocks of time are taken by other programs. I have to learn the ward's schedule so I can

figure out a time when learners can come. And this has to be worked out around the other timetables in the other wards. It's a nightmare sometimes. Just when I think I've got it sorted out, they'll have a staff meeting on the ward. I'm not invited, but not because they don't want me. They just don't think to notify the school. Then they change their schedule. When I hear of it, it's already in place and all I can do is try to adapt."

Effort toward creating better communication between the school and mental health workers seems to come only from the instructors. They are told when they complain about poor relationships that they should do this or that to improve communication. But as this person observed, no one on staff thought that she/he had some responsibility to reach out to the school.

"I really get upset because I see her [program's coordinator] bending over backward to keep the nurses and other therapists informed, but they never make any effort to inform me. Sometimes she makes me angry because I'd like to tell her to forget it because they never return the favour. But she says that you just have to keep it up."

The director of social workers in a mental hospital sheds some light on what lies behind these problems. When asked about students attending school, he said that few in-patients have education as a goal. People are concerned about getting a job and resolving conflicts with family and friends. When asked about the school program in the hospital where he worked, he made this candid comment.

"I don't want to offend, but education isn't foremost in our clients' minds. I think the social workers here must have over 150 people on their caseloads and I can't recall anyone who's planning to go to school after they leave here."

"What about the school program in the hospital?"

"Well, I think patients go to school because it's something for them to do. It passes the time. So it's helpful in that way, I suppose. But we don't think school will be a big part of their plans when they leave so we don't go out of our way with it."

An instructor confirmed this viewpoint.

"The staff said they weren't interested in their school work. They wanted to get some idea of how patients would react to living in the community and they saw the school as the closest thing to community life in the hospital. All they cared about was attendance and whether they did work, but not what they did or anything like that."

When a hospital patient was told about the social worker's reply, she pointed out

that most people in the hospital did not know the school existed or that they qualified to go to school.

The problem of poor working relationships between instructors and mental health workers is not restricted to the hospital setting. When a program coordinator tries to contact a student's doctor or community nurse for advice, he comes up against a stone wall, an experience shared by others.

> *"I tried to read about it after she told me she was taking Lithium. But what I read didn't make much sense and I didn't know where to find things I could read. So I called the doctor with the student's permission. I only got to the receptionist. She never let me talk to the doctor. She passed messages to him, but what she told me didn't help."*

In part the problem here concerns confidentiality. Doctors and all mental health workers are ethically and legally forbidden to pass on information about people they are treating unless specific rules are followed. Stating over the phone that a student gave you permission to call does not satisfy these rules. In some provinces forms must be completed. However, confidentiality alone does not explain the problem. A psychiatrist tells about her experience with a patient's instructor.

> *"I got constant calling from this school. Every time he did the slightest thing, they were on the phone. Usually asking the same question. I'd have to listen to one teacher rap about the evils of psychiatry. Then I told the receptionist to stop accepting the calls. I guess that wasn't the most effective way to deal with the problem. It's true that something needs to be done."*

These issues are real and troublesome. Instructors are outsiders, schools have low priority, people are sent to school for the wrong reasons, communication is too often in one direction only. In an article on how mental health workers can share 'power' with families, Dr. Spaniol and his associates make this suggestion, which can be applied to instructors as well.

> *Recognizing that families are a key resource in the mental health delivery system and that the attitudes and availability of mental health professionals have often been a hindrance rather than a help is only the first step. Professionals need to act on this awareness by learning to share power over decision making and service delivery with families* (Spaniol,et al. 1984: 79).

They make some specific suggestions about effectively including family members and making accessible community resources. Some strategies which they recommend for improving cooperation may be helpful to literacy and mental health workers and thereby improve their service to students/clients.

Strategies for improving instructor-mental health worker relationships

While their comments are aimed at the need for mental health workers to share information with families, Dr. Spaniol and his associates' comments are worth repeating here.

> *Families with psychiatrically disabled relatives need information, practical advice, and resources from mental health professionals. Professionals need to collaborate with family members to improve the rehabilitation potential of the severely mentally ill* (ibid.: 83).

In Box 22 their suggestions are summarized with instructors and students' needs in mind.

MAKE GOOD USE OF INFORMAL EXCHANGES OF INFORMATION

In a mental hospital with a large school program, the instructor had difficulty getting good information. Trying to organize actual meetings to discuss student progress with other therapists yielded few results. Her solution has been to rely on informal exchanges.

> *"I can't really say there is one way. We need to be aware of basic issues, like danger. We need general information, for example, that a learner's behaviour is related to manic-depression, or that we're likely to see this kind of hallucination. This is what seems to work. We get some of this general information. A lot depends on informal exchanges."*

MINIMIZE COMMUNICATION DIFFICULTIES

In a hospital with several instructors, flexibility can be maximized by assigning instructors to teach just those students living on one or two wards. This may reduce timetable problems and make it easier for the instructor to become familiar with the staff who work with their students. Typically, if a hospital has a large school, the program coordinator attends ward meetings to discuss students. Unfortunately this places the coordinator between the therapists and the instructor and decreases flexibility because it adds another link in the communication chain. Each time a link is added, communication becomes more difficult. This instructor notes:

> *"I have to tell my supervisor what we're doing in class and any problems I'm having. She goes to the meeting and discusses it. Then she comes back and discusses it with us [teachers]. It's really clumsy and I don't get the information I wanted. Sometimes I'm not sure what I wanted to know. Maybe just the chance to see how concerned I should be about this or that. That's hard to convey second-hand."*

Box 22

Working Together

Be open

Mental health workers need to be open to negotiating and clarifying their goals with instructors and students. Listening to them will most likely result in instructors and students being more open to mental health workers' points of view. Being open means checking assumptions, being honest, expressing concerns, and acknowledging differences of opinions and feelings.

Acknowledge limitations

Instructors and students need to hear mental health workers recognizing their own limitations. Hearing that these professionals are struggling to determine how best to help someone encourages everyone involved to recognize her/his own limitations. This awareness fosters genuine cooperation.

Develop relationships

Mental health workers must realize that it isn't enough simply to treat a patient. The person they treat is a member of a community. Workers must develop a relationship with local service groups, community networks, family, and other groups close to the person's community.

Become a teacher

Mental health workers must become mental health educators. They should teach the people they treat about mental disorders and treatment methods.They must learn how to give practical advice on how to deal with common behaviours and drug management problems related to a particular disorder.

Learn about community resources

Mental health workers need to know the resources available to the people they treat. That is, they should get to know the people who run these programs and become familiar with how their work is affected by other treatment methods. Instructors and students should share with community nurses and doctors what they know about the influence of treatment on learning.

Adapted from L. Spaniol, et al., 1984.

LINK CLASS ACTIVITIES TO WARD ACTIVITIES

Supporting adult education programs within mental hospitals is justifiable and practical according to Dr. Mahmood.

> *Since a certain functional level of literacy is essential for a person's safety and security, such skills are critical if the chronic psychiatric patient is to be rehabilitated into the community* (Mahmood, 1983: 7).

He then names some skills and shows how they are linked to the person's mental health. Several adult educators support this functional approach to adult education. That is, students are taught skills to improve their ability to function successfully in their communities. Instructors working in hospitals have observed how the

relationship between the mental health workers and the school improves if the school uses teaching material which supports the therapy programs. For example:

> *"What really helped was when the staff and I came to see literacy as part of the student's therapy. If they couldn't read or write, we saw that as a problem area that needed work. So they came to school just like any other group. This was the literacy group. And I used things from the ward, like pamphlets and instructions. They have this diary for the residents to use. If they can't write, I work with them so they can keep up their diary. You'd be surprised how many things I can use from the ward, even math. It has really improved my relationship with the staff."*

KEEP TRYING

It is important to recognize that working with your student also means working with the therapists. The idea of adult education for students in mental hospitals is new for mental health workers. Change requires patience, as this instructor notes:

> *"It's important to develop a rapport with staff. You do it gradually. When I first came, I worked in total isolation from the staff. I didn't know them. I was a little reticent about approaching them, not knowing what their reaction would be. I was also lacking in self-confidence. Then I started. If I hadn't seen somebody [a student] for a while, I'd phone the ward or walk over there. After a while I found out the staff liked that. They liked knowing that I cared and wanted to know what was happening. It's still a one-way street. I call them. But it's changing very slowly. This is part of working here. You have to just keep trying. Some are easier to teach - I mean the staff - than others."*

INSTRUCTOR TRAINING

Other useful suggestions for improving instructors' relationships with mental health workers are mentioned in Chapter Six, in the section on organizing a training workshop for instructors who are interested in teaching in institutional settings. For example, an orientation tour is recommended so that the instructor can become familiar with the hospital and the people who work with patients.

Conclusion

This concludes the issues which literacy workers raised about themselves. Some problems and strategies mentioned in Chapter Five will apply to what has been discussed here. In fact, several of the topics listed there might have been placed here, or vice versa. No issue is clearly either the literacy worker's or the student's. Nor is this list complete. In future editions of the handbook, we hope to expand this list and revise our descriptions of the problems and the strategies suggested for confronting them.

Chapter Five

PROBLEMS AND STRATEGIES FOR STUDENTS

THIS chapter describes seventeen problems identified by students, literacy coordinators, and literacy instructors that arise when students are being treated for mental disorders. These problems, also listed in Box 23, are presented in alphabetical order. Following each discussion of a difficulty are strategies for minimizing them. The stategies were recommended by students, teachers, and mental health workers. It has not been possible to include every concern raised by students and literacy workers, but the most frequently occurring ones are included.

Box 23

Problems Described in Chapter Five

Problem	Page
Attendance	97
Attention	99
Blurred and Double Vision	102
Changing Courses	103
Comprehension	107
Delusions	109
Drowsiness and Fatigue	111
Hallucinations	113
Holidays	115
Hygiene	117
Mental Regression	118
Problem Solving and Organization	121
Realistic Goals	126
Responsiveness	130
Stigma and Stereotyping	133
Tardive Dyskinesia	135
Tremors	136

Some key points to remember

FLEXIBILITY

Flexibility is a characteristic that all literacy coordinators and instructors should possess if they are to impliment successfully the strategies mentioned here. Problems can be identified and strategies can be recommended for minimizing them, but the best suggestions are of little use unless instructors and coordinators are flexible enough to adjust to their students' changing needs.

STRUCTURE

Adult educators favour interacting with their students in ways that ensure student participation in the decision-making process. Typically, adult education is interactive, participatory, and voluntary. Nonetheless, students and instructors tell us that students treated for mental disorders, especially for schizophrenic and brain injury disorders, are not empowered by the instructor who asks them to contribute to the planning and evaluating of lessons. While structured activity may rightly be avoided in most adult education classes, strategies suggested here rely on the instructor's ability to create a structured learning environment. Asking a student being treated for some disorders to decide what she/he wants to learn today can become, in the opinion of one instructor, 'downright cruel'.

LOW EMOTIONAL EXCITEMENT

Characteristics of several disorders are aggravated by a high level of emotional excitement. People suffering from brain injury are fatigued by their struggles to cope with it. Learning materials that encourage emotional involvement seem to trigger delusions and hallucinations in schizophrenia. Furthermore, high emotional excitement has an adverse effect on those who find it difficult to focus their attention and to concentrate on practicing. As you read the strategies recommended in this chapter, you will discover that the lesson for educators is clear: for productive learning and living to occur, people being treated for most mental disorders do best in an environment which is relaxed, quiet, and supportive.

LEARNING TO LEARN

The importance of teaching students to know and use the strategies suggested here must be emphasized. Literacy workers may be more successful in their work by developing and improving their teaching skills; however, the best teacher is one who teaches a student to understand her/his problems and to develop strategies to compensate for them. For instance, much is gained by creating an environment free of distractions for the student with limited selective attention. And much more is gained when the student learns how to create for herself/himself an atmosphere which reduces distractions. Indeed, each strategy mentioned here should be considered a lesson which an instructor can teach a student, as the need arises. That is an objective worth pursuing.

WHAT CAUSES LEARNING PROBLEMS?

Certain characteristics of a disorder can create problems for a student, but in some cases the drugs used to treat the disorder appear to aggravate the student's difficulties or create their own problems.

Attendance

The problem

Psychiatric disorders can affect class attendance in a number of ways. A student stops coming without notice, reappears after weeks or months of absence, or leaves abruptly after class has begun. Such erratic attendance may be related to mental disorders and treatments in a number of ways. For example, schizophrenic disorders pass through recurring stages. During the remission stage attendance may be good, but when the student begins to 'get sick', attendance becomes a problem. Disorders and treatments which inhibit concentration or cause restlessness and forgetfulness cause students to become frustrated with classwork and leave. An instructor puts it this way.

> *"You have to be pretty understanding about this. Some days they can't work and they know it. You don't want them to come over and try because they'll just freak out on you. So you really have to respect their judgement. When they get psychotic, they can't handle school work."*

Irregular attendance presents a problem for those teaching in community programs, whereas it is not an issue for instructors working in hospitals. In hospitals, when a student does not appear or leaves abruptly, the instructor contacts the ward and visits the student to encourage her/him to return to class. In the community, the situation is different. Perhaps a tutor has travelled a considerable distance to teach only one student. When the student fails to appear or leaves after a few minutes, the instructor is frustrated and time seems wasted. A student comments on this problem.

> *"Sometimes I sleep-in. When that happens I know the teacher gets pretty upset. Then I don't want to see him again because I'm afraid that he'll be upset and won't want to work with me anymore. I just have to get off my ass and get to class. I can be lazy alright, that's for sure. But I think it could also be the meds."*

His comment reminds us that a side effect of most drugs is drowsiness. The student may be taking his medication at a time when the greatest sedative effect coincides with the time he is to leave for class. This results in lateness.

For students, one consequence of living in an institution for a long period of time is that they tend to depend on authority figures to make even simple decisions.

Schedules are set and maintained by those in charge. A student recognizes the effect this had on his attendance even after he was discharged from the hospital.

> *"At the hospital - I was there quite a long time - they'd come over to the chair and remind me to go to school. Sometimes they'd have to wake me up. I guess I got into the habit of depending on them."*

Strategies for attendance problems

KEEPING INVOLVED

Encourage students to continue with their class even though attendance creates concern. If the student decides to stop, assure her/him that you understand the problem and encourage the student to attend when possible. An example of this support is provided by an instructor working with a student who has been enrolled in one correspondence course for three years.

> *"The schizophrenia comes and goes. Sometimes he just can't work. He can get pretty bizarre. Then he'll go back to it. It has taken a long time, but I'm a gauge for him. When he's feeling better, he knows that he can return to his work. Even then it goes slowly."*

PROVIDING REMINDERS

Thought disorders associated with schizophrenia can distort a person's ability to judge time and follow schedules. Helping students to overcome this problem and keep to a schedule should be an important goal of the literacy program. If the student 'gets sick', a schedule may not work, but it can be helpful for overcoming the effects of confusion associated with some disorders and drugs. For example:

> *"My student asked me to call him before I leave home and I do, but I always remind him that getting to class is his responsibility, and I don't pretend that I'm not upset when he doesn't show or comes late. I try to help, but I don't want to take the responsibility for being on time away from him."*

A community nurse adds the simple suggestion of a calendar.

> *"At the beginning of the month we go through the calendar. We mark the days and times for classes and other events he needs to remember. The exercise helps him to remember and it fits in with teaching literacy."*

ADJUSTING THE TIME WHEN MEDICATIONS ARE TAKEN

Drowsiness and fatigue may be related to attendance problems because the student is taking drugs which are sedatives. In many cases, the time when the drugs are taken can be changed so that the sedative effect interferes less with attendance or studying. If drowsiness is the problem, suggest that the student discuss this with the doctor.

Also see: Attention; Changing Courses; Drowsiness and Fatigue; Holidays.

Attention

The problem

Attention is a problem when a person cannot focus for very long on one task, when noise and other stimuli create distractions, or when switching attention from one thing to another and back again is difficult. Box 24 describes in greater detail various types of attention problems.

Attention problems affect learning because they inhibit a student's ability to practice what she/he is trying to learn. Information which is not sufficiently practiced cannot be stored in a person's memory. As a person's attention waxes and wanes, information is stored in disconnected bits and pieces. This creates confusion which in turn contributes to other memory problems (See Chapter Three). A student comments:

> *"It's very hard to concentrate even while you're asking me these questions. It seems that when you start talking, I'm paying attention. But before you finish, I'm just about not following what you're saying."*
>
> *"What happens when you haven't been concentrating?"*
>
> *"It's hard because you feel embarrassed. You feel like you're kind of stupid because you didn't catch it."*
>
> *"So do you let it go by?"*
>
> *"Yea, most of the time, and hope you'll say something else that I'll catch so I won't seem like I'm not listening to you."*

Another student believes that poor attention made it difficult for her to keep up with her class. She felt confident that she could do the work, but when the instructor was speaking, her attention wandered. After struggling for some time, she dropped out.

Schizophrenia, depression, and brain injury have been identified as causing attention span problems. Lithium, a drug for treating manic-depression, has been identified as causing attention problems, and similar concerns have been raised about the side-effects of drug therapy in general. This student, for instance, links the sedative side-effects of his medication to his concentration problem.

> *"I get tired and I can't concentrate. I try but I just either wander off or start falling asleep. I'll work so hard at staying awake that I forget what I'm staying awake for. So it's pretty frustrating."*

Box 24

About Attention

Attention defined

Attention is a general term which refers to a person's ability to focus on one task. Attention is a conscious activity: the person makes an effort to focus on one thing. Attention is also an unconscious activity: for example, a red car is more likely to get our attention and hold it for a longer time than a white car.

Attention-deficit disorder

This is a psychiatric disorder which has received much notice lately. It is usually described as a developmental deficit which hinders attention. Typically the person is 'hyperactive'. The excessive activity interferes with the ability to focus attention on one task.

A Hierarchy of Attention Skills

Sustained attention (attention span)

The ability to remain focused on one task. Difficulty with sustained attention produces a 'waxing and waning effect'. This causes gaps in what the student sees and hears. These gaps cause confusion and poor comprehension.

Selective attention

The ability to 'filter-out' competing sights and sounds and irrelevant information. The person cannot study unless distractions are removed from her/his surroundings. When speaking and writing, the person becomes distracted and may go off the topic.

Alternative attention

The ability to switch from one task to another and back again. Listening and taking notes is a good example.

Divided attention

The highest level of difficulty, this is the ability to perform two tasks at once. Reading and typing or talking on the telephone and taking down a message at the same time are two examples.

An instructor makes a related point.

> *"Mostly he could work for no more than an hour, an hour max. So I'd plan for that, even though he had to stay in the class for two hours because he couldn't go back to his unit until then. But some days were a lot better than others and he could work almost straight through the hour or even longer. So I learned to have something else planned to do on the side, just in case."*

Instructors working in hospitals claim that because patients attend so many therapy sessions during a day, they become tired and cannot concentrate on their studies. Working in libraries, storefronts, and on hospital wards where there are distractions is also seen as causing attention problems.

"People come and go in this class all the time. The telephone rings and someone has to get up to answer it, or a voice comes over the intercom. He has enough problems. He doesn't need to work where there's so much going on. Even if we sit by the wall, it helps. If we can work in one of the side rooms, what a difference it makes."

Strategies for increasing attention spans

DIVIDE TASKS INTO SMALL UNITS

Breaking each task into smaller units is the recommendation of this instructor.

"You break it up and keep the time spent working in school short, one hour maximum. During that time we do two to four things. About 15 minutes are spent on spelling; then we switch to reading."

Another instructor adds:

"We keep each thing in little chunks and we go over things a couple of times during the time we work together. See, I'll do a bit of reading with him and then we go to some questions. We'll get one or two done; then he'll start making mistakes. So right there I switch and we go back to reading. Then a little time on spelling and over everything again. It works pretty well for his attention. We just don't let him slide."

ALLOW PLENTY OF TIME AND VARY ACTIVITIES

A study of attention span difficulties with people suffering from brain injury makes two suggestions: avoid complex tasks and allow plenty of time for task completion. This includes allowing for frequent breaks. This instructor notes:

"Change is important. You plan for it. The students take frequent breaks. Time for a cup of coffee, or a walk over to the drinking fountain. If they try to work at what they're doing straight through the hour, I don't think many could do it. With some of the fellows we practice working a little longer at a time. I can't say I've got a good method for doing that, but in math you can see that some can stay with it longer now than when they began. Math is good for this kind of practice."

Concentration improves if students combine reading with writing brief notes. One student says:

"I write everything down. It really helps if you write it down. If the teacher reads it and I read it again, it helps. But it helps if I can write notes. It's the writing that really helps me remember and concentrate. I don't always like doing it, but it helps."

Another student reports that after reading a paragraph of a short story, she writes a sentence describing what happened. Her notes become an outline which she uses to help find answers to questions at the end of the story. To divide up her time into a variety of activities, to help keep herself active, and to reinforce what she has learned, she types her notes using a computer after she has read the story.

STAY ON TASK AND KEEP QUESTIONS CONCRETE

When attention is a problem, a casual remark to redirect the student back to the topic often gets things back on track. If the instructor calmly persists in bringing the student back to her/his place in the text or to the purpose of the question, the student is likely to respond. Tangential thinking can often be prevented by phrasing questions in a way that requires a concrete response. An instructor provides this example.

> *"He'll wander off like he did this morning. He picks up on an idea in the book and off we go into the meaning of life. But I just keep trying to bring him back to the question in the book, or I'll create a question that has a very definite answer."*
>
> *"Can you give us an example?"*
>
> *"Well, the text wanted him to give two reasons for whatever it was. Off he went. So I said, 'Yes, I understand it's complicated, but what was the name of the person who....' It took a while, you saw that, but after a while he gave me the right answer and then in a moment or two he was back to work."*

Also see: Comprehension; Drowsiness and Fatigue; Mental Regression; Problem Solving and Organization; Responsiveness.

Blurred and Double Vision

The problem

Blurred and double vision are common side effects of many drugs. In most cases, blurred vision is a passing side effect, subsiding after the body adjusts to the drug; however, it can reappear. Vision problems have obvious effects on reading and writing.

Strategies for blurred and double vision

CONSULT A DOCTOR

If blurring persists, the student should be advised to speak to her/his doctor, who

can often prescribe medications to reduce blurring. Eyeglasses may also be helpful.

USE BIG PRINT

It is not necessary to purchase large print material. Regular print can be enlarged with most photocopy machines until the problem passes.

SUPPLY A MAGNIFYING GLASS

A program coordinator suggests that no class should be without one.

USE COLOURED PAPER

Yellow paper seems to work very well. Along similar lines, one student uses sunglasses to help him read when his vision is blurred. He finds that the fluorescent lights increase the problem and cause headaches.

SHIFT TO A TAPE RECORDER

Teachers can record stories and their students can answer questions orally. One instructor adjusts this way.

> *"When he has blurred vision, we catch up on the oral language work that I know we should be doing. I tend to let it go by. Oh yes, and we do spelling. You can do a lot of spelling and comprehension work. I don't think it has to be a problem."*

Changing Courses

The problem

Students frequently asking to change what they are studying is a common problem. The request may come shortly after beginning the program or each time they begin to work on new material. Some students take on too many courses at once or select courses that are beyond their abilities and then must drop them when the workload proves too difficult.

Because literacy courses are non-credit, formal course changing does not pose a problem. Typically it is a matter of adjusting the course to meet the student's needs. However, even in these informal programs, students may ask to switch to math or just spend time looking at magazines rather than working on assigned tasks.

Moving in and out of hospitals and changing residence has an impact on continuity. As this instructor observes:

> *"Some students' files are thick with incomplete courses. A big reason for it is that they come and go. When a fellow comes back [to the hospi-*

tal], I'll ask him if he wants to continue with his work. Very often the answer is no. If I persist, he won't come to school."

A second instructor adds:

"With some students I find we work backward or not at all. We start at a place where the student can work and we move forward slowly. Then we approach a new concept and the student wants to go back. 'Let's go back to do more ....' I try to encourage them to take it a little at a time, but there always seems to be a point where we're faced with either working backward or changing the course."

A literacy coordinator spoke of the impact anorexia nervosa and manic-depressive disorders have on course changing. In her experience persons with these disorders are 'driven by the need to do great things'. This leads them to take on as many courses as possible, but nothing is ever finished. When a person is manic, it is difficult to judge what can be accomplished during a given period of time. Taking too many courses or too difficult a course may be the consequence of this problem.

Difficulty in making decisions and a tendency to withdraw from social contact are two characteristics of schizophrenia and anxiety disorders, which may be important here. Course changes may be the student's strategy to avoid social encounters. In short, there are reasons to believe that changing courses may be a problem related in some way to the characteristics of various mental disorders.

Strategies to minimize course changes

OFFERING ASSISTANCE HELPS STUDENTS TO STAY WITH A COURSE

Two students suggested the importance of instructors helping them to stay with their courses. One student puts it this way.

"I don't know how to ask for help. That's one of my problems. So I count on the teachers asking me if I need help and telling me how I am doing. If I don't get this kind of help, I'll either quit or I'll try something else that may be easier."

The other says:

"Some teachers are good. They work with you a lot. Others just give you a course and tell you to ask for help if you need it. I'm not very good at asking. These teacher's here don't wait for me to ask, so I keep at it because they work right with me. Last place, I changed four, five times. Here, never."

GETTING THROUGH THE TASK AT HAND

Instructors can encourage students who want to change or quit to finish what

they are working on that day. If necessary, modify the lesson to make it easier to complete. The goal is to help students get through their immediate problem. If they still want to change the next day, make the change.

TRY SHIFTING FOR THE DAY INSTEAD OF CHANGING THE COURSE

Shifting the task for that day may keep the student on course, but this strategy can create a problem if day after day shifting takes place. In time you may discover that the student has made little progress. Shifting must be monitored closely to avoid this.

SETTING DOWN A POLICY

Unlike informal courses, those offered for credit (e.g. a high school diploma) present a greater problem for changing courses. Credits are not earned until a course is complete. In some cases, a student who was admitted to a course which required a minimum enrolment wants to drop the course. If she/he does drop it, there are not enough students to continue the course, which causes hardships to others. Moreover, credit courses usually involve a fee of some kind, which may be lost.

To allow for these difficulties one program permits students to change if it is not a repetitive act. Another permits one course change at the student's request. Before a second change is approved, the school reviews the student's record. What about the danger of students dropping-out in the face of such a policy? The coordinator replies:

> *"I'm not afraid of that. If they withdraw it is too bad, but they were not likely to make any progress anyway. Some students have a difficult time with procrastination. Living in an institution doesn't help them to take responsibility. I don't think we help them by contributing to the problem with concessions."*

GOOD ASSESSMENT AND CAREFUL PLACEMENT

Providing good assessment and beginning instruction well within the student's comfort zone goes a long way toward avoiding course changes. An instructor describes this strategy.

> *"I start them below their potential, you see. I work them up from there. I give them encouraging, easy stuff to do at first so they get used to the routine and start feeling comfortable about being here. Then I gradually escalate the level of difficulty. You have to start them below their potential; otherwise you lose them. I've lost a few that way. I don't have all successes. I guess that's important for people to remember. They're not all going to be successes and if you frustrate them too early you lose them."*

Box 25 provides guidelines for assessing students. Note that a good assessment accomplishes two things: the instructor and the student understand the student's strengths and weaknesses, and the student learns about the literacy program. Fur-

Box 25 Suggestions for Productive Assessments

Avoid unnecessary assessments

Students may resist assessment because they have been overly assessed. Treatment involves a great deal of assessment. Assessments are repeated because reports are lost, the person's case is turned over to a different agency, or it is the same agency but in a different location. If the student has participated in another education program, make every effort to get previous reports and use them instead of putting the student through another assessment.

Introductions and orientation

Treat the initial assessment as a two-way situation: a time for you to get to know the student and a time for the student to learn about the instructor and the literacy program. Introduce other staff and students. Take a 'tour' of the facility where the program takes place (e.g. library and workrooms). Use this time as a way to get to know the student: How well does she/he speak English? Is she/he comfortable meeting and talking to others? Does she/he have good communication skills (e.g.listening, interrupting)?

Be sensitive to stress factors

For an adult, the literacy class may be the first class attended since public school. Returning to 'school' brings back emotional issues, especially fears of failure, the need to please the instructor and to form good relationships with other students. Do not be surprised if the student seems upset, even angry. The stressfulness of returning to school is a reason for the teacher to avoid formal testing at first.

Use on-going and informal assessment

Students have good and bad days. These are often characteristics of disorders and side effects of medication. Only on-going assessment will adequately identify the student's abilities and achievements.

Reality check

Discuss with the student her/his short-term and long-term goals. This 'reality check' helps determine how realistic the student is about what can be achieved and whether the student understands what the instructor and the program can offer. Note this unfortunate experience.

> *"Someone let her think that we could offer college classes if she finished her work. We don't even have credit courses for high school. And she was reading at about grade three. Now why go along with it? It was a lot harder to talk about this after she was misled."*

Trust the student:

A stereotypical view of people being treated for mental disorders is that they cannot be trusted. Experienced literacy workers trust the people they assist unless a student gives them a good reason not to. Students may provide inaccurate information simply because they are confused about their past accomplishments in school, but not necessarily because they are trying to deceive anyone.

thermore, while assessment may involve the use of formal, standardized tests, casually observing students reading passages that vary in difficulty and then talking with them about what they have read can also serve as an assessment.

In some programs the person doing the assessments is not the instructor. There are several advantages to this. The person doing assessments gains experience which makes her/his work more efficient and productive. The student and 'the assessor' have sufficient time to discuss results and time is available for a wide range of assessment activities, including orientation tours. Meanwhile instructors are free to teach. Furthermore, if the student becomes upset during the assessment, her/his anger is not directed at the instructor. A disadvantage is that the person doing the assessments 'stands between' the student and the instructor so the likelihood of having communication problems increases. Also, using another person can hinder on-going assessment.

Also see: Attendance; Comprehension; Drowsiness and Fatigue; Holidays; Problem Solving and Organization.

Comprehension

The problem

Word recognition is not the same as comprehension. It is quite possible for a student to recognize words at an advanced level but not comprehend what she/he is reading. For example, one instructor notes:

> *"I have very few who can't read at all. But I get many people who can read every word with almost no comprehension. I had a student who took out a lot of books. He read them but with no comprehension. We make a mistake because we see the person reading and forget that maybe he can't comprehend what he is reading. I've found this is common when the person is being treated for schizophrenia."*

A psychiatrist offers this explanation.

> *"People suffering with schizophrenia are more rigid in their thinking. They tend to be less flexible than most people. Thinking in general terms, thinking abstractly gets them into difficulty. With schizophrenia, students can't access higher thinking abilities because certain bits of the brain aren't functioning as they should. They think concretely. I suspect this affects their ability to comprehend what they read, but they may do very well at naming the words."*

Several instructors interviewed believe that students lack the confidence to answer comprehension questions. Word recognition is straight forward and errors do not cause much distress. However, when a student makes a mistake on a comprehension question, the error is more devastating.

> *"She cringes when she makes an error on that part of the assignment. She has problems with comprehension, but it's also fear. She's been dumped on more than once for saying something 'stupid'. Now she doesn't trust me. I think she understands more than she lets on."*

Strategies for improving comprehension

ASSESS FOR COMPREHENSION

Standardized tests may be used to assess reading comprehension. If these are not available, an instructor can devise her/his own assessment. Have the student read several short passages, each one at a different level of difficulty. After the student has read a passage, ask her/him a variety of comprehension questions. Some should be factual (e.g. asking about names, dates, or events), and others should require more abstract thinking skills (e.g. the main idea of the passage, how the character might feel; what is likely to happen next).

KEEP THE MATERIAL SHORT

Since difficulty focusing attention may be related to problems with comprehension, it is advised to keep the amount of material covered short.

> *"It is very important that the material should be short. One or two paragraphs is plenty to handle. The students being treated for schizophrenia have lots of problems with attention, so you don't give them too much at once. Short and structured. Then some recovery time. I mean a rest. Then take on another short section."*

PROVIDE IMMEDIATE, POSITIVE FEEDBACK

After each response to a comprehension question provide immediate evaluation and feedback. Emphasize the student's correct responses. If an item was missed, do not emphasize the mistake but encourage a second, correct response. This approach may encourage second guessing, a kind of risk-taking. This encouragement is important for students who may comprehend what they have learned but hesitate to respond for fear of making a mistake. If properly supported, second guessing can help students to gain confidence.

STRUCTURE THE ACTIVITY

Structuring the reading activity assists comprehension. For instance, after reading a short passage, one instructor has his student answer a set of short, specific questions. The questions follow a fixed pattern. The first question asks for a factual

point using the true/false format. The second also asks for concrete information, using a short answer format. The third requires thinking skills that are more abstract than concrete, depending on the student's ability. Here is an example.

1. Alison was working as a waitress when she lived in Toronto. True or false?
2. Does the story begin before or after the war?
3. Why was Alison fired from her job?

Another illustration of modifying materials to improve comprehension involves carefully selecting and sequencing questions in order to transform abstract concepts into concrete ones. Consider the difference between these two sets of reading comprehension questions.

Abstract:
What was the setting of the story?
Who is the hero? Why is she or he the hero?

Concrete:
Where did the story take place?
When did it take place?
Name the characters. Which one of these is the main character?
What did she or he try to achieve? Did she or he achieve it?
How did the story end?

Also see: Attention; Changing Courses; Mental Regression; Problem Solving and Organization.

Delusions

The problem

A detailed description of delusional thinking is provided in Chapter One. Here it is sufficient to say that a person is delusional when she/he believes something despite having information which tells her/him that the belief is not true. A delusion is not rational. No amount of reasoning helps the person to realize that the delusion is not true. How a delusion may interfere with learning is illustrated by this instructor's experience.

> *"He was studying biology. Every so often he would tell me that he wrote the textbook, that he worked with two other doctors and they made up the lessons. It didn't matter that he had a hard time understanding the book. He wrote it and that was that."*

Delusions cause problems of attention and concentration for the student. One student explains the effects of his delusions.

> *"Everything is pretty slow. I can't even play crib. I can read. And it's hard to concentrate. The worst thing is afterwards. The next day it leaves you wondering what happened and how much of it was true. You know, was it all just in my head or was some of it true? Maybe it's because I'm still a bit sick, but I keep trying to figure out if any of it was real. That makes it hard to concentrate."*

Delusions can be mistaken for circumstantial speech. Delusions are false ideas. Circumstantial speech is a thought disorder in which speech is not focused: the person can never get to the point or stay on topic. The instructor can try to help the student refocus by asking the student to identify her/his main point.

Strategies for controlling delusions

AVOID TRIGGERING THE DELUSIONS

Delusions can be triggered by stressful and frustrating events or by any stimulus from the environment. Several instructors and a psychiatrist think that the use of controversial material can trigger delusions. They recommend that instead of using controversial materials, instructors should use stories with low emotional impact like fiction and history. For a more complete discussion on the use of controversial reading material, see Chapter Four.

HELP TO SET THE DELUSION ASIDE

Delusions are easier to turn on than off, but they can be encapsulated. Encapsulating a delusion means that the student can set the delusion aside and get on with work. Instructors can help a student to encapsulate by following this psychiatrist's suggestions.

> *"In a calm voice assure the student that you understand that he is experiencing these beliefs. You know that they are true for him. Then ask the student if he can set them aside for now and do some work. Suggest a change in activity which may help him to focus. For example, suggest that he do something he likes doing. Keep trying. Keep calm and be supportive."*

An instructor put it this way.

> *"Usually they are stuck on some question and they go off into a delusion. Well, I don't have time for delusions so what I do is get them back on task by helping them over the place where they are stuck. I continuously focus in on the work and avoid the temptation to play analyst with them."*

I observed an instructor helping a student to encapsulate. The student could not

solve a problem. He began to speak about the theory of relativity. Calmly, the instructor kept asking him to solve the problem at hand. When it was clear that he could not, she went over two problems which he had already solved. She talked about them and praised his work. She suggested that they provided a clue for the difficult problem. The student stopped talking about relativity and showed an interest in explaining how he answered the two problems correctly. In a few minutes the student was back on task, although it was clear from his occasional comments over the next hour that the delusion was encapsulated rather than eliminated.

Drowsiness and Fatigue

The problem

Drowsiness (or sedation) is a common characteristic of mental disorders. It is also a common side effect of drugs used to treat most mental disorders (see Chapter One). It can have an adverse effect on attendance. At its worst, students cannot stay awake during class. They are wrongly accused of 'faking it' and being lazy. In less severe cases, the student is awake but unable to concentrate and attention waivers. The following comment illustrates the impact drowsiness has on learning.

> *"I get tired because I take these meds. There isn't anything they can do about it. That's what they said. It bothers my school work. The teacher thinks I'm faking it. I've told her it's the meds, but she doesn't listen to that. I wish they [nurses] would speak to her so she'd understand I'm not faking it."*

Fatigue is a weariness or tiredness which normally follows periods of extended effort. Fatigue may be mental, following extended mental effort or boredom; emotional, following excessive conflict or frustration; and muscular, following physical activity. Fatigue may be a side effect of some drugs (e.g. several antidepressants) or a characteristic of schizophrenic, depressive, and brain injury disorders. In the case of brain injury disorder, the person becomes fatigued as a result of the extra physical, emotional, and mental effort needed for everyday activities and stress.

Also, fatigue creates frustration which in turn causes more fatigue. Students treated for brain injury and other mental disorders are often worn out after an hour of class work.

Strategies for accommodating and reducing drowsiness and fatigue

ACCOMMODATION

Combat drowsiness and fatigue by carefully planning class time and by pacing lessons. Whenever possible, classes should be offered in the morning. More difficult tasks (i.e. those requiring much concentration) should be studied at the beginning of

the day. In the case of fatigue, a work period should last no longer than 20 to 30 minutes and it should be followed by a rest period.

INCREASE PHYSICAL ACTIVITY

To reduce drowsiness, encourage students to get up and walk around. This student writes notes as a form of physical activity to keep alert.

> *"I write everything down. It really helps if I write it down. It's the writing that helps me to remember because if I'm writing I don't get as sleepy. Reading is harder because it's hard to be active. I've tried walking and reading, kind of pacing. Taking notes while I read works a bit."*

REST PERIODS

In one community program the staff provides a place for the student to take a short nap. According to the student, this strategy works.

> *"If I take a nap for about 20 minutes, I feel fine and I can work for the rest of the time I'm here. After the nap I understand what I'm doing."*

DOCUMENTATION

A teacher may want to document the incidence of drowsiness so students can report it to their doctors. One instructor working in a hospital reports drowsiness to the student's nurse. She finds that handing over this information brings about changes which improve students' alertness. Another instructor came to an agreement with the student to keep a record of his drowsiness. This was turned over to the doctor with the student's permission.

> *"You can keep a record of how the meds may be causing trouble and talk to the student about it. If you give it to the student, he can pass it on to the doctor and perhaps something can be done. The dose might be lowered, or the time when it is taken might be altered, or the drugs could be changed. You keep a record and then they have something to go on."*

REQUEST A CHANGE IN MEDS OR THEIR ADMINISTRATION

If you consult the boxes in Chapter One which list the side effects of drugs, you will see that not all drugs are equally sedative. For instance Haldol, Orap, and Trilafon are antipsychotic drugs that have low incidence of sedation. It is reasonable for a student to ask her/his doctor if one of these drugs can be used in place of more sedative drugs. But both student and instructor must realize that it is not always possible to make changes and that other side effects may be equally problematic. For instance, while Haldol and Orap are not as likely as some antipsychotic drugs to cause drowsiness, they are more likely than others to cause rigid and cramped muscles, tremor, and restlessness .

An alternative to switching drugs is changing the time when they are administered, and in some cases the dosage may be reduced. After speaking with a stu-

dent in her program, a literacy coordinator followed this course of action.

> *"I didn't have any difficulty phoning and telling the nurse that he was coming to class and was okay for the first half hour, but then he would fall asleep. And after half an hour I'd wake him up and he'd go for a coffee. He would come back and work for another half hour. I asked if they could give him his medication after class, when he got back to the unit. And they did and he was fine. They meant well. They thought that giving him the drug before would make him better in class, but it backfired. So you can ask for changes and it can help."*

Some psychiatrists are open to patient's suggestions. They will change the dosage, the time when the medication is taken, or the medication itself, if this will help the patient participate in an educational program. Others are not easy to speak to about medications. In one interview a student reports his concern about raising this subject with his doctor.

> *"I wasn't scared to question the doctor. I just didn't know how to put it if I asked him. Should I say, 'This drug is putting me to sleep, I can't concentrate, and I can't do my school work'? I didn't know how he would take it. I debated with myself for three weeks before I could talk to him. Finally I did it. I told him, 'I can't do my work.' He took it real good."*

This student received advice from his instructor on how to approach his doctor and it helped. He thought this was something instructors could do. A psychiatrist came up with a similar suggestion.

> *"The teacher could take some time to help the student prepare a list of the issues he wants to raise when he comes to see me. That would be a big help. A lot of the patients come in here [her office] and they become frightened or confused. An issue like schoolwork will get lost. The list would help."*

Also see: Attendance; Attention; Comprehension; Mental Regression; Problem Solving and Organization; Responsiveness.

Hallucinations

The problem

Hallucinations as a major characteristic of schizophrenic disorder is discussed in Chapter One. Here it is sufficient to say that hallucinations refer to hearing voices,

seeing nonexistent things, or feeling sensations for no apparent reason. Although the sensations are not caused by an actual stimulus, the experience is very real. Hearing voices is the most common hallucination associated with schizophrenic disorder.

It is common for a person who is having a hallucination not to let others know it is occurring. An instructor puts it this way.

> *"Most patients don't really confide in you if they are hearing voices. Sometimes I find out when I am talking to them. You realize they are hearing voices when they start talking to the voices. I have had students come to school because they like it here, sit down in front of a book, and then appear to talk to the wall all afternoon."*

The major adverse effect of hallucinations is distraction. The voices, for instance, compete for the student's attention, and since they can be quite persistent they often win. For this student, the voices he hears dictate what he may study.

> *"I can't study that [math] because he won't let me. He doesn't want me to study that. He still won't let me study math. He'll come back, so I'm not going to [study it]."*

This student tells about his hallucination.

> *"I get words I know how to spell but at the moment I don't know how to spell them. I know what the word is but if I can't get the word like that [snapping his fingers], I'll start to play around with it in my mind and I'll hear talking so I kind of forget what I was working on."*

Strategies for reducing the effects of hallucinations

PATIENCE AND COOPERATION

You cannot eliminate hallucinations, but in cooperation with the student you can help her/him to minimize their effects on learning. Create an atmosphere in which the student knows that you are there to work with her/him when they subside.

> *"You don't get very far with these guys, but I do go through with it. I don't always work with them but just go through the motions a bit. I guess I'm counting on the time when the hallucinations are under control and they will still want to come here and work."*

One teacher at a hospital has made an arrangement with an occupational therapist whereby the student works with this therapist when he is experiencing hallucinations and he returns to school when the hallucinations are under control. Physical activity, associated with occupational therapy, is easier for the student to manage when he hears voices. This type of cooperation goes a long way toward helping students make the best use of their time.

HELP THE STUDENT CONTROL THE HALLUCINATION

A person experiencing a hallucination is not completely out of touch with reality. Many have techniques for controlling the voices they hear. A psychiatrist believes that people well enough to be involved with an educational program should be able to control their hallucinations with some assistance. Instructors can help students to take control by asking beforehand if the student has ways of dealing with them. Some are able to ignore the hallucinations; others have learned tricks for making the hallucinations go away. For example, 'outtalking' a voice can often help. A psychiatrist explains:

> *"The voices may be coming from the voice box in some way that we don't understand. When the patient talks he takes control of the voice box and the voices stop or become less intense. This is just an idea at this stage, but some doctors think there is something to it. Anyway, there is surely no harm in trying it. It really is a matter of sensitivity. The instructor simply must pay close attention to what the student is doing and saying."*

REDIRECTING ATTENTION

If the student cannot stop the hallucination, see whether she/he is able to have her/his attention redirected to something else with your assistance. For example:

> *"You can focus in very short bursts because attention isn't very long. They're coping with the voice and me too. Kind of like two people talking at the same time. So they tend to go back and forth between the two voices. If the voices keep at it, then they have to talk to the voice and settle it down before they can go on with me. It can be a funny situation actually. But, you know, I figure the guy got here and he deserves to be taught. You don't get far some days, but you make some progress and the student keeps coming back."*

Another instructor keeps 'checking-in' when he believes a student is experiencing hallucinations. His efforts are focused on helping the student keep in touch with reality.

> *"I'll just ask her a few questions about things I know she is interested in like baseball. If she's hallucinating, sometimes she'll start to talk to me about the baseball game and then she may do a bit of work."*

Also see: Attention; Delusions; Problem Solving and Organization.

Holidays

The problem

Seasonal changes and holidays have a notable, adverse impact on every aspect

of participation in educational programs. Christmas is particulary difficult for people in institutions, especially for those experiencing their first Christmas in a mental hospital or prison. Personal events such as birthdays and anniversaries create frustrations and depression, a point observed by this program coordinator.

> *"Next to Christmas the hardest time for students is their children's birthdays. Anniversaries are also disruptive. One that seems really tough are anniversaries of divorces and the death of family members. In some ways Christmas is easy because you know about it. But the others you probably don't know about and unless you've been working with the students for a while, they probably won't tell you what's wrong."*

Additional to the emotional distress caused by holidays and special events, staff vacations are often accompanied by program changes. These changes disrupt schedules, which, in turn, can affect literacy program schedules.

Perhaps the most difficult change is brought on by summer vacation. Single parents often rely on school staff to supervise their children during the day, which allows the parent to work, spend time with friends, and attend programs. The school schedule provides structure both for the children and their parent(s). Summer vacation (and other extended school holidays) removes this structure. As this student recalls, the consequences can make participating in a literacy program nearly impossible.

> *"Once June comes, it's harder to get my son to go to bed at night. He stays up to watch T.V. and then he sleeps in. I was going to school at around 2:00 when he was in school, but now that doesn't work unless my neighbour is going to be home to watch him. But I can't count on it. It's harder on me too because when his day goes haywire so does mine. So I don't feel very good and I lose my temper with him. That doesn't help, I can tell you."*

Strategies to accomodate holidays and similar disruptions

FIGHT FOR PUBLIC FUNDED DAY CARE

Here is a problem which requires more than cooperation between student and instructor; indeed, literacy coordinators, instructors, and learners were at a loss to suggest strategies to help overcome the disruptive influences and emotional distress which often accompany holidays. But one student makes this suggestion.

> *"Well I guess you could get me day care for the summer like we used to have. Now that's gone because they cut it back, so I have to watch him."*

AVOID ASSUMING THAT STUDENTS WANT TO CELEBRATE HOLIDAYS

It is common practice to incorporate seasonal celebrations into lessons. In hospitals it is typically taken-for-granted that people prefer to celebrate holidays such as Christmas, even though patients cannot be with friends and family. The instructor

who offered this suggestion questions this assumption.

> *"I don't assume that the students I work with want me to make a big deal about Christmas. I try as best I can to keep things pretty much the same. If they want to do something special, I'm happy to do it as best we can, but I don't get all hyped-up and decorate the room. Some years it seems like they just want it to go by; other times we do something special. You have to play it as it comes along."*

Also see: Responsiveness.

Hygiene

The problem

Poor hygiene causes problems with body odour and bad breath. This may occur because a student has poor housing, where decent facilities for good personal care are not available, or because of habitual dependence on hospital staff reminding the person to keep clean, which is a consequence of institutional living. Or it may be a consequence of the onset of an acute phase of the person's mental disorder. Poor hygiene affects the learning environment by interfering with the instructor's ability to work with the student and by negatively influencing the attitude of others in the class toward the student. Its importance varies with the tolerance of those around her/him.

Strategies for dealing with hygiene problems

TAKE THE DIRECT APPROACH

Students suggest speaking directly to the person about hygiene problems.

> *"You can suggest a shower. You shouldn't just let it go. But there isn't anything else you can do after that. You'll just have to leave it."*

> *"Straight forward, I'd say. That can be alright. Someone came right out and told me that I had really bad breath. I told them that I knew it. They suggested seeing the doctor for mouthwash. I did and it helped."*

A nurse agrees, but adds that it is best for the person with the problem to hear about it from someone she/he knows and trusts.

> *"Very often they have been told about this before. Some have been confronted quite often. This is an on-going problem. I try to remind the fellows*

that they have to think about how they are coming across. It works best when they hear about it from someone they know. And you have to remember that with these fellows it can be a sign of a recurrence of their illness."

An experienced instructor gave this advice.

"I have to feel comfortable bringing it up. When I do, I can get all kinds of reactions. One guy asked me if I was his mother. Another told me it was none of my business. But I don't back down so easily. I tell them that it is my business because I need to concentrate to help them, and the odours make it hard to concentrate."

Another suggested rewarding cleanliness by using a behaviour modification approach.

"The important thing to remember is to reward them when they are clean. I don't overdo it, but I'll quietly tell them that they look nice and thank them for being so considerate. It helps. Some fellows won't listen. I'll say something and they'll get up and leave. I let them."

Also see: Stigma.

Mental Regression

The problem

A mature mind has developed the ability to think abstractly. Abstract thinking allows a person to learn principles underlying social rules, to use concepts, to perceive relationships, to appreciate metaphor, and so forth. A simple sentence can be written and understood with concrete thinking. Abstract thinking is needed for writing and understanding complex sentences. The loss of abstract thinking skills is called mental regression.

Difficulties with attention, comprehension, and problem solving and organization, mentioned in this chapter are related to mental regression. An instructor describes it.

"He doesn't have much imagination. He doesn't offer ideas or think ahead. If I ask him questions with yes or no answers or fill-in, he does alright. But multiple choice or anything complicated causes problems. Yet, he told me that he finished grade ten and did pretty good before he got into trouble and stopped going to school."

Mental regression can seriously affect how the person relates to others in unexpected ways. For example:

"You have to be very careful when you make jokes. Jokes often depend on pretty subtle uses of language. If their thinking is very concrete, they'll take the joke literally and this can cause a great deal of trouble.

Regression is a very serious issue. They can't do what they were able to do before. It isn't that they've just forgotten. They've lost the mental ability. Their thinking is just too concrete."

Lost study skills may contribute to mental regression, but psychiatrists interviewed believe it is caused by mental disorders. Schizophrenia in particular is associated with mental regression. Dementia related to substance abuse disorders also involves mental regression. Some side effects of antipsychotic drugs have been identified as contributing to it too.

Strategies to identify and accommodate mental regression

MAKE A PROPER ASSESSMENT

A good assessment includes being sensitive to the possibility of mental regression. The person doing the assessment must take the time to find out if mental regression has occurred and how it may affect the student's performance. Tests which assess the level of abstract reasoning are available; however, they usually require special training to administer and interpret. Assessment does not need to be done with formal tests (See Box 25, page 106). Talking with the student can help the instructor assess the student's abstract thinking abilities. For instance, ask the student to describe an event from memory. Listen for the use of abstract concepts. The response will provide useful clues as to the student's abilities. Use the illustrations provided in Box 26 to help assess the level of a student's abstract thinking abilities.

USE FEWER ABSTRACT QUESTIONS

In the strategies which accompany Attention (page 99), Comprehension (page 107), and Problem Solving and Organization (page 121) you will find methods for transforming material to reduce the amount of abstract thinking required to complete tasks successfully. Transforming abstract information into concrete information makes it less difficult to learn and retrieve information. The more an instructor can use concrete language and visual representations, the better the outcome. Charts, pictures, and diagrams transform abstract information into concrete information.

SUPPORT STUDENT'S EFFORTS TO RECOGNIZE AND COPE WITH REGRESSION

The disappointment and frustration which accompany mental regression are a large part of the problem. The instructor must take the time to help the learner to adjust to her/his present abilities. This will require a lot of support. Allowing the student to talk about the frustrations is very important. An excellent strategy is to emphasize material which does not have an apparent 'grade level.' Take this example.

Box 26

The Concrete and Abstract Thinker: Ted and Grant Describe Their First Working Experiences

Ted was studying to be a biologist when he was first treated for schizophrenia. His story is an example of concrete thinking related to mental regression. Since he was a college student, we may assume that he was capable of abstract thinking, but his story contains very few abstract concepts. While Grant is being treated for the same disorder, his story illustrates that mental regression has not occurred because his story demonstrates his grasp of abstract concepts.

Ted's Story

"I started working when I was 12. I delivered newspapers. I'd get on my bike and I'd bike around the neighbourhood where I lived and deliver the papers. I'd deliver about 100 papers every day."

"What did you like about the job?"

"I liked biking around. I liked the money. You get paid pretty good when you deliver newspapers."

"Anything you didn't like?"

"I didn't like doing it when it was really cold."

"Was the company fair to you?"

"They were okay. I didn't have to work if I got sick or something."

Grant's Story

"My first job was painting houses for my uncle. He wanted me to work for him because he thought it would give me something to do so I'd keep out of trouble. I liked that job, but in the summer bees came around and made it really hard to work. He had two or three other fellows working with him. So I was low man on the totem pole."

"You didn't like that?"

"Well, not much. I'd have to do all the dirty work. You know, like the scraping and cleaning up. He wouldn't let me paint windows because I wasn't as steady as the others. It was alright. I saved some money and it kept me out of trouble. It was a big relief to my mom."

"It may be that when you are doing math, the student doesn't think about grade levels. I actually think this is the reason why it is easier for someone who can't handle the reading to work in math."

Also see: Attention; Changing Courses; Comprehension; Problem Solving and Organization; Realistic Goals.

Problem Solving and Organization

The problem

The inability to solve problems and to organize successfully becomes apparent in a variety of ways. Minor problems are treated as major ones and a person seems unable to solve problems effectively. The person cannot organize her/his time and things. Planning is cumbersome with an inordinate amount of effort spent on carrying out a plan. Often movements are very inefficient; time is spent backtracking, rechecking, or travelling here and there with no apparent reason. Irrelevant information is brought into a decision making process and decisions are made and remade. The person is easily side-tracked. Frustration follows quickly when efforts to solve problems fail. Of course this aggravates the situation.

Other indications of problem solving and organization deficits are poorly organized writing, an inability to set and maintain schedules, and difficulty setting priorities. The student continues with a pattern of behaviour although it does not lead to desired results. This may include a tendency to repeat and to recall a particular bit of information without any apparent reason. A student describes his experience.

> *"Instructions overwhelm me. I just can't get down to work if there is a lot to do. I find it very hard to concentrate on getting one thing done, and I go on to something else. I have a hard time starting and finishing a job. Just getting started is hard for me. It's very hard to start one thing and finish it. Usually I don't even start it because I think I'm going to fail. So I don't even start. I keep thinking negatively and I just give up."*
>
> *"When you're overwhelmed what happens?"*
>
> *"I get listless. I just walk in and then I'll go over by the window or up to the library and lay down. I get really tired."*

A literacy coordinator describes her experience working with a student being treated for manic-depressive disorder.

> *"He never completes anything. He begins everything and completes nothing. He says that everything has to be done perfectly, so he never completes anything. He'll start on something, then he brings up a million things that he could do to solve the problem. Some of them make sense but some are outrageous. He treats them all the same. So it's no wonder he can't decide."*

These problems are characteristic of schizophrenic and paranoid disorders and brain injury disorder. They also occur with depressive and manic-depressive disorders, and sometimes with substance abuse disorders.

When a disorder disturbs continuity of thinking - as does thought disorder associated with schizophrenia - a problem to be solved or the purpose of a plan is lost in a maze of unrelated ideas and distractions. A psychiatrist speaks about the problem.

> *"Any disorder, like schizophrenia or a brain injury, which effects the frontal lobes of the brain interferes with a person's ability to organize, categorize, and plan. With a severe mental disorder, people can't do these things well at all. It takes them a very long time to grasp a rule for organizing things or tasks to be done in a sequence, and if you change the rule for some reason they will ignore the change and continue following the old rule. There is very little ability to be flexible."*

A common form of brain injury is damage to the frontal lobes of the brain. When these lobes are damaged, the 'executive function' of the brain is impaired. This function is needed for generalizing, integrating, and classifying information. These are essential abilities for problem solving and planning. Frustration, which accompanies disabilities caused by damaged executive function, results in a loss of emotional control, which in turn contributes to poor judgement.

Schizophrenia interferes with the ability to appreciate consequences. If you cannot appreciate consequence, it is very difficult to solve problems and plan.

Characteristics of depressive disorder, such as feeling worthless and hopeless, create distractions. Preoccupied with 'feeling blue', the person loses self-motivation for problem solving and planning.

A related problem is a poor sense of time. People have difficulty when required to judge how long it will take to complete a task. They may also fail to understand relationships between past and present. For instance, a poor sense of time affects students in a history course. According to their teacher, the students could not grasp the causal relationship between events happening in the distant past and those closer to the present. For them the past was one period and the present another.

Strategies to improve problem solving and planning

SELF-INSTRUCTION TRAINING

An approach developed to improve problem solving involves teaching students to organize by following a series of well defined steps. They learn the steps by following the behaviour of a model. The steps are:

1. Observe a model performing a task.
2. Perform the task while hearing instructions from the model.
3. Perform the task while whispering the instructions to self.
4. Perform the task while just thinking the instructions.

By following these steps, the student uses 'thinking-out-loud' to rehearse instructions and guide activity. Evaluation is on-going. In this example, a student learns to

write the cursive form of the lower case letter l.

> *"Now I start at this line and go up to the next line. Yes, that's right, and now I go back just a bit and come straight down. Yes, I cross over the line on the way down, like this."*

When the student makes an error:

> *"Okay, that's a mistake. I should go back to here and do it again."*

Box 27 illustrates how to use this method to improve problem solving and planning when performing life skills.

Instructors with students suffering from brain injury are advised to teach them to follow a similar sequence: (1) rereading directions, (2) repeating verbalized instruction before initiating a task, (3) encouraging on-going evaluation by an observer and the student, (4) providing opportunities to ask questions and to request assistance, (5) providing plenty of opportunity to repeat similar problem solving and organizational activities.

Box 27

Problem-Solving Sequence and Self-Instructionsfor Missing the Bus

Problem solving sequence	Self instructions
Step I: Identify the problem	1. I missed the bus. 2. I need to get to work.
Step II: Make a Plan	1. I am in a hurry. 2. I can't walk, so I must wait for the next bus. 3. I'll find a public phone and call work to say I'll be late.
Step III: Follow the plan	1. I find a public phone. 2. I get out the 25 cents. 3. I call work and tell them what I will do. 4. I return to the bus stop. 5. I get on the next bus.
Step IV. Did the plan work?	1. I called to say I'd be late. 2. I got on the next bus. 3. People at work knew I would be late. No one was upset.

Adapted from J. Gumaer and T. Headspath, 1985: 375.

USE SUPPORTIVE, STRUCTURED TEACHING METHODS

Structure is very important; indeed, the need to teach with clearly stated guidelines, expectations, and consequences cannot be over-emphasized. An instructor speaks to the need for structure.

> *"They need structure in their lives in order to cope with their lives plus this illness that's superimposed on their lives. The one thing you work for with people who suffer from schizophrenia is structure. According to my daughter's psychiatrist, you start with medications, then structure."*

The importance of structure is stressed by most students, instructors, and mental health workers. In Box 28 a selection of their comments are given in order to emphasize its importance. Some specific strategies to increase structure are:

1. Post schedules in the teaching area and provide each student with a schedule of her/his activities.
2. Start each lesson with a contract that includes a checklist. The checklist should specify the time required to complete the task, the quantity of material to cover, and the proficiency expected (e.g. 3 out of 4 correct).
3. Begin with short, success-oriented assignments and increase their length and complexity as the student progresses.
4. Give simple, concrete directions. Take the student through several examples following your instructions.
5. Provide constant feedback.
6. Keep the student's work area clear of materials not needed for the immediate task.
7. Keep the classroom well organized at all times.
8. At first provide limited options when asking questions. As the student improves, slowly provide additional options.
9. Give the student a short list of tasks to complete in a given period of time. Discuss with the student how she/he will organize her/his time. If the student is unable to set priorities or establish an order, provide assistance. Even model it until she/he is able to do it.

MAKE TIME SEQUENCE CONCRETE

The instructor who taught history found that she could improve her students' abilities if they used time-lines, pictures, and similar devices for making time and sequence more visual and concrete.

Also see: Attention; Comprehension; Drowsiness and Fatigue; Mental Regression; Realistic Goals.

Box 28

Structure and Mental Disorder: An Essential Strategy

People interviewed for the handbook placed considerable emphasis on structure. While adult educators tend to favour less structure, it is important to stress that in order to learn, students being treated for several mental disorders need structure.

An instructor

"Some require a lot of structure. We go through each lesson step by step. We try to take it one step at a time. They often want to rush ahead because they don't see the need for each step. I have to help them understand this. I try to teach using a step by step approach as a skill. Some agree to the structure. Some resist. Some materials depend more on structure than others. Because they're adults I don't push, but I keep to it; otherwise we wouldn't get anywhere. It's hard to do!"

An instructor

"When I began, I'd say to a student, 'What do you want to do?' And I'd bring out a bunch of things and talk about their good and bad points. They'd get terribly frustrated. One fellow said, 'Well you're the teacher.' And I'd think, 'He must want me to have all the answers.' It was a minor disaster. They'd come to class and sit and read magazines. Actually, it was cruel. They had a devil of a time making decisions and I was forcing them to decide. I've learned that I have to provide them with much more structure than I would sometimes like to."

A student

"For me it's true. If I don't know the subject, I need someone to show me how to do it. If you give me lots of choices, I get confused. I have to think about each one and then I can't make up my mind. I like to work on math because the teacher says 'Yes, this one is right' and 'No, that one is wrong. See, you did this and you should do it like this.' See, it's really good like that."

A psychiatrist

"Structure is very important. A successful teacher will increase structure and reduce ambivalence. I wouldn't use multiple choice questions, for example, too many options. True or false would be much better. Lay down some clear parameters. Set up definite, clear options. These people have a lot going on in their heads at one time. It's too much already. That's part of the problem. So you don't want to add any more than is necessary. They'll have a hard time focusing to make a decision. So reduce the options and you'll help them to decide. If you really want them to decide and plan for themselves, then make it possible for them to do it. You act as a filter and give them 2 choices and they'll decide. Be straight forward."

Realistic Goals

The problem

Describing another person's goals as unrealistic is a tricky business. We do it based on our common sense notions of what people can achieve. This will always include our stereotypes and prejudices about the capabilities of an individual or group of people. These concerns surface in what this instructor observes about the ways in which students judge what they are likely to accomplish.

> *"I don't think we want to say definitively if someone's goals are realistic or not. But it's hard when someone who can barely remember what we covered last week tells you again and again that she wants to be a dentist. Some can be very grandiose. The expectations waiver, depending on how they feel. When someone's manic, the sky's the limit. With schizophrenia, it depends on the individual: how they feel and what's happening with their treatment. Some sell themselves short. It's not just the illness. A lot depends on the person."*

Another instructor thinks the problem is complicated by the student's past experience with school.

> *"Sometimes their plans are unrealistic. Sometimes they're confused about what they completed in school. They don't know what grade they were in. All this adds to the confusion and makes it hard to judge what they once were able to do and where they are now."*

It is not uncommon to meet a learner with a college degree who can barely read or solve simple math problems. It is difficult for these people to be content with striving for something which they were once able to accomplish with ease. Faced with these difficulties, some refuse to make goals, while others refuse to adjust to their limitations. For instance, individuals suffering from severe brain damage typically create unrealistic expectations. Difficulties with memory, concentration, physical coordination, and stamina keep all but a few from returning to the type of work they did before their injury. Victims of brain injury are motivated by a strong desire to return to a normal lifestyle. They plan for the future based on what they accomplished before their accidents. These unrealistic expectations lead to further frustrations when they fail to get or keep jobs held in the past.

As previously noted, the problem of defining realistic goals may be complicated by a tendency for others to underestimate a person's abilities. In one study, for example, patients and their doctors shared modest, realistic views on what vocational achievements the patients could expect; meanwhile, nurses were overly pessimistic. In striving to help, treatment staff may inadvertently underestimate the student's potential and lower the person's self-esteem.

Institutional living has its own negative impact on reaching goals. People who

have spent long periods of time in hospitals have few opportunities to make and carry-out long-term plans. Without this practice, they lose their ability to make plans and experience the reality of success and failure.

We judge the reality of goals by signs of progress. Of course measuring progress, even agreeing on what counts as progress, is difficult to do. Take this comment, for example:

> *"It's the schizophrenia. For a long time I can work just fine. Then I can get sick and it prevents me from working. I'll take a long time off, but when I feel much better it's there for me to pick-up again. I've been at it about three years, because I have to set it aside, and I need to go back over a lot again. But I like it. And someday I'll finish it. I'm not in a hurry. The others might be, but I've got the time."*

This student is not unique: intermittently attending school for years, working at approximately the same level, and sometimes regressing or moving ahead are common experiences in school programs located in mental hospitals. This instructor commented on progress as it relates to 'good days and bad days'.

> *"You can't really talk about progress like you would in a regular school, because there are days when she really moves and I'm not prepared to keep up with her. Then you'll have a stretch where she can't work, or doesn't even come. She has her good days and bad days, or weeks. So I measure our progress by what we do on the good days. Maybe that's unrealistic but we keep at it alright."*

When we speak of goals we assume that people 'want to get ahead'. Is this a fair assumption to make? People's values differ. Moreover, some students fear success. This instructor comments:

> *"I've had two who have real problems with success. Because they were doing so well, they left. It's a problem we don't recognize. Some students can't cope with success."*

Strategies for helping students set realistic goals

PROVIDE HONEST FEEDBACK

The most important strategy is to provide honest feedback when a student discusses her/his goals. This instructor comments:

> *"Like the gentleman we were talking about who plans to go to university. I do have to talk him down and say, 'Now look if you get your grade twelve, you're going to be as well educated as half the people in Canada, and I really don't think it's realistic for you to go to university.' I have to be honest with him. I can be wrong. And every now and then I may say, 'Oh, you can do it,' even when I think he can't. I know it and I think he*

does, but it's hard to face."

Another instructor said:

> *"These adults are getting treatment. You don't make anything easier by telling them something may work when you know perfectly well there isn't a chance. When they ask, we sit down and talk. We don't always agree."*

PROVIDE COUNSELLING

Students often lack accurate information about their level of achievement and what is required to reach their goals. This student's comment points to this problem.

> *"I thought my reading was okay because I didn't read much; so I never really had any idea of how much I needed to learn. And when I saw women working as dental technicians, I just thought what they did looked pretty nice. But I didn't know how much they had to study and that they went to college for it. So I had this idea that that was what I wanted to do. It was a downer at first to find out about college. I don't think I'll do it because of other things. But it's better to know that than just have crazy dreams. People look at you funny when you say what you want to do."*

Career counselling is important if students are to know what is required to achieve certain goals. This should go far beyond merely discussing the student's intellectual abilities or achievement levels. For instance, does the student understand what is required to complete a training program or to earn a university degree? Entrance requirements should be discussed as well as tuition costs and availability of financial assistance. What are the job prospects once the person has finished? Studying drama has its own rewards, for example, but does the student realize that a steady income is not likely to be one of them? Does the person have the stamina and the tolerance for emotional stress associated with reaching some goals? The list can be extended.

A good career counselling program should be part of an adult literacy program. Assistance in organizing one may be provided by career counsellors working for community colleges, community service organizations, or government agencies. Consult the Mental Health Association in your area for the names of people who can help you develop counselling skills.

LISTEN TO THE STUDENTS' GOALS AND BE SENSITIVE TO CHANGES THEY WANT TO MAKE

Students' self-ratings of their abilities and plans must first be heard before one can say what is or is not realistic. As this literacy coordinator points out, the merit of a student's goals should not be judged by how well they meet the aims of the program in which she/he is participating.

> *"The workshop's supervisor thinks their goals are to make money and work their way into another program. I think the patients are there be-*

cause they get some satisfaction from participating in the program and it's a chance to spend some time in a different place. This is what many have told me, but the workshop director doesn't seem to notice."

If a literacy worker does not listen to and respond sincerely to the student's goals, the student may adopt what she/he believes are the acceptable goals for a particular program. When this happens, unrealistic goals are learned and frustration is the result.

TEACH STUDENTS TO PLAN SHORT-TERM GOALS:

Making realistic long-term goals is learned by making realistic short-term goals. This is important for both the student and the instructor.

"You can't expect an adult to learn to read overnight. That's why it's important to divide things into smaller units. See how long it takes to complete one unit; then it's easier to get some idea of how long it may take to complete the full task."

TEACH PLANNING AND GOAL MAKING

Therapists in rehabilitation programs have developed methods to teach people to plan and develop realistic goals. Results of their efforts suggest that students can learn to set realistic goals if given the opportunity to practice this skill. For example, the exercises in Box 29 and Box 30 teach students to be aware of the time it takes to complete a task.

PROVIDE FOR GENUINE SUCCESS

Frustrated with her student's constant reference to becoming an engineer, a instructor brought in a civil engineering text book to demonstrate the 'absurdity' of the student's goals. He realized it and stopped coming to class. To avoid reacting to frustrations in this way, this instructor takes the opposite direction. He first has the students experience success by completing tasks that he knows they can handle successfully. This encourages them and helps them to feel comfortable. Then he gradually gives them more difficult material, stopping before the material becomes too difficult or frustrating for them. However, the instructor must also be careful not to start with materials that are so easy that students find them demeaning. It may help to explain to your students that you are using a trial and error method to determine what level of difficulty they can handle comfortably.

Providing opportunities for a genuine sense of progress is essential for coaching students on how to make realistic goals for themselves. This student would agree.

"Right now I don't know about my future. I'm thinking about it. Coming to school takes a lot. I don't know if I can continue, so I'm not making plans. But what helps right now is when the instructor tells me I'm progressing. That matters because then I can say it's worth doing because I'm doing okay.

Also see: Attention; Drowsiness and Fatigue; Mental Regression; Responsiveness; Stigma.

Box 29

Judging Time

1. Identify a simple mental or physical task (e.g. solving four math problems which are within the student's skill level or stacking books on a shelf).

2. Ask the student to estimate how long it will take to perform the task.

3. Have the student perform the task while you time how long it takes. To avoid frustration, help the student realize that the first guess may be wrong and that she/he should not worry.

4. Discuss the results. Did the student misjudge the time needed? Did she/he feel rushed?

5. After the student has revised the estimate of the time needed to complete the task, have the student repeat the task.

6. Repeat this activity using progressively more complex tasks.

7. Change the difficulty of a task by changing the setting of the task. For example, the student may perform a task in a room where there are no distractions. When she/he can estimate the time it takes to complete this task with some accuracy, the task is performed in a place with distractions, usually sights and sounds. Students being treated for schizophrenia are often unable to ignore sights and sounds, making concentration difficult. Distractions interfere with planning. Doing the task first in an isolated spot, then in a place with distractions helps the student to learn how to accommodate the effect that distractions have on her/his ability to estimate time and to meet goals.

Responsiveness

The problem

Students being treated for schizophrenia and depressive disorders may show little enthusiasm for their studies. No matter what the student works on or the quality of the results, the student shows the same 'dead-pan' response. Quite the opposite is likely to occur during the manic phase of a manic-depressive disorder when the student seems overly enthusiastic and praises everything the instructor does. As one psychiatrist puts it:

> *"Mental disorders are most confusing. People suffering from schizophrenia can't draw their boundaries very well. It takes time, sometimes a great deal of it, before they will trust you enough to let you come close. Depression isn't quite the same, but it looks as though the person doesn't care. When you're depressed, it's very difficult to show any emotion, let alone some enthusiasm. But some disorders are the exact opposite. This person will draw you in. Everything is glorious, but the fellow might not do any work. The teacher will find it difficult."*

The ability to experience and express satisfaction with social activities appears to be a

Box 30 Creating a Checklist for Making Goals

Set the Goal

Set a goal for what you wish to learn today.

Identify Resources and Tasks

Identify the skills, tools, and other resources needed to meet the goal. Identify the tasks to be performed.

Reassess the Goal

If resources are not available or if skills must first be learned, the goal may need to be changed. If so, set the new goal.

Gather the Resources

Bring together whatever is needed to meet the goal (e.g. books, writing material, other aids).

Learn the New Skill

Carry-out the tasks identified for meeting this goal. If skills and/or resources are needed which have not yet been recognized, reassess your goal.

Assess the Results

Look at what was accomplished. Was the goal met? Did you do more than meet your goal? Did you fall short of your goal? What was needed which you did not plan for (e.g. more time, better work space, skills or resources, etc.)?

Adapted from Anthony, et al., 1988.

major problem for depressed persons. After the depression passes, the person may continue to show little excitement for work or leisure activities. This is exactly what this student reports:

> *"I'm dull. I'm incapable of enjoying a conversation or an ice cream cone, even when I'm feeling healthy. Everything seems boring. Since the ECTs back in 1971 and all this time I've spent in hospitals and on drugs, I can't enjoy my beer. You know what I mean? I can't seem to put that back into my life."*
>
> *"How do other people, like teachers, respond to you?"*
>
> *"I'm the dull guy with a deadening expression. That can't make them feel much like working with me. I think it puts them off, although they really try and I like them. I haven't really had friends since 1971 because I can't seem to enjoy anyone's company."*

Another student makes this comment.

"I'm too serious. So I'll withdraw and I mostly want people to leave me alone. The instructor has a really friendly attitude. We talk a bit and I feel good, but that seems to get her to talk too much. And then I don't think it's helpful. It depends."

When these problems were mentioned to instructors, they knew exactly what the students were talking about.

"You know that you don't get a heavy response. You just get a deadpan expression that a lot of the people have. It looks like people are not responding; yet they may be. Don't get the idea that they are bored. That's a good point. You're not likely to see the standard visual cues that tell us, 'this is interesting, this is great'."

On the other hand, over-responsiveness also creates difficulties. This typically happens with learners being treated for manic-depression and some personality disorders. An instructor notes:

"Part way through a lesson, he tells me how much he appreciates all the work I do for him, and he goes on and on. I try to express some appreciation for his comments and get back to the work, but then he gets overly excited about that too. He'll say something like 'Oh, yes, let's do it. I like this so much!!!' When you write this down put three exclamation marks after that and you'll get the sense of what I'm saying. It's very hard to take."

Another instructor felt she had to watch her comfort zone. The learner she worked with kept offering to be helpful as a sign of his appreciation for the instructor's efforts.

"It became too much. I kept having to say that I didn't need any assistance, that I liked tutoring, and things like that. But he wouldn't take no for an answer."

Until the student becomes accustomed to working with a particular instructor, the instructor can expect a low level of trust and perhaps little response. Medications, or changes in treatment may complicate matters, just as changes in the effect of the disorder will influence the person's enthusiasm for school or most other social activities.

Strategies to allow for unexpected responsiveness

SEE BEYOND APPEARANCES

An effective strategy for helping to minimize difficulties caused by the 'deadpan expression' is training yourself not to see this response as a sign of boredom. An instructor says:

"If you look closely, you'll know they are taking it all in because you

can see their eyes twinkle. They don't burst out with it, unless they're manic, but then that's another story. You stay with it and after a while you get some trust happening."

This comment was pursued with a literacy coordinator working with students coming out of a local hospital.

"Some students aren't able to respond. Maybe it's the stage of their troubles. We often see this when medications are being changed. When it happens, the only good reason for them to come to school is for a change of atmosphere. And it's important that they keep coming because in a while they may feel better and we can continue. If they stop when they're down like that, they might not want to come back, and for many that's a real shame. You just have to wait this period out."

MAINTAIN A COMFORT ZONE

Maintaining a comfort zone was the one strategy suggested to minimize the problem of over-enthusiasm. Keeping the instructor-learner relationship 'more business-like' was suggested by a community nurse who faces similar problems in his work. This suggestion was echoed by a student being treated for manic-depression.

"You have to be really up front about it. Don't be wishy-washy or you're sunk. I think the teacher is afraid to say, 'Look, I know you're pleased. Now let's get on with it.' They're afraid that they'll hurt the person's feeling. And they probably will, but I think it won't last and the two of them can learn to work together. But you can't be afraid to be firm. Sounds good, but I don't know if it will really work."

Awareness that the deadpan expression is not a judgement of teaching ability or student interest should help to improve the instructor's morale. Dealing with too much enthusiasm may prove to be a more difficult problem.

Also see: Delusions; Drowsiness and Fatigue; Hallucinations; Mental Regression; Stigma.

Stigma and Stereotyping

The problem

A stigma is a physical or behavioral difference which has an adverse influence on a person's social acceptability. Physical limitations such as blindness and stammer-

ing are examples. Mental disorder is a stigma. Forced confinement in a mental hospital, orphanage, or prison creates a stigma. A stigma is similar to a stereotype. Both are group-shared ideas about the alleged nature of people making up another group, without any consideration for the accuracy of these ideas or individual differences. A stigma associated with people being treated for mental disorder is dangerousness, for example. The only difference between stigma and stereotype is that stigma is always negative, while some groups 'benefit' from 'positive stereotypes' (e.g. 'Blonds have more fun').

Sociologists use the term master status to refer to another characteristic of stigma. That is, the negative or unusual behaviour becomes the most important (i.e. the master) characteristic of the person or group. For instance, an individual treated for schizophrenic disorder may be a parent, a friend, a carpenter, a lover of folk music, and so forth. But all these are buried by her/his master status: a schizophrenic.

Stigma creates enormous problems for its victims. They are often unable to associate with those who are not victimized by the same stigma; thus they are almost forced to spend time with people victimized by the same stigma or else remain alone. The ability to get jobs and housing is affected, as is almost every aspect of life. This student explains:

> *"I feel very nervous all the time. I want to steer conversation away from my mental disorder. It's very hard for me to interview for a job, knowing that the boss is going to ask me what I've been doing for the last while, during the time I was in the hospital. I might have to lie, and I don't want to but I'm forced to. But he'll [the boss] get suspicious: 'Why am I only taking lower paid work? Why am I taking a job with low responsibility?' If I tell him that I can't take too much pressure, then he'll realize there's a problem and that finishes it."*

Students participating in adult education programs in a hospital school may refuse to return to the school program after their discharge from the hospital because they want to minimize the stigma associated with mental hospitals. Without alternative programs which are genuinely accepting, these students simply discontinue their studies. For some, the reverse is the case, as this instructor notes.

> *"I have a great deal of trouble getting out-patients placed in community programs. The community programs won't take them. They say the staff aren't trained. That's probably true, but I also know they are afraid of these people. Some students refuse to go to the community programs. They'll keep coming back here. During the day you can see them hanging-out near the hospital talking to patients. There's no place else for them to go. Or they are afraid that they'll be mistreated if they go into programs that aren't set up to take them."*

Strategies to help overcome stigmas and stereotypes

SUPPORT THE WORK OF SELF-HELP GROUPS

Overcoming stigma is an on-going struggle. Self-help (survivor) groups publish

material and participate in social and political activities to work towards the elimination of stigma and negative stereotyping. Literacy coordinators and instructors can support their work. Using materials produced by these groups in literacy classes and tutor training courses is one way to fight against stigmatization. The Resource Guide includes printed and audio-visual materials which may serve this purpose.

DEVELOP CONTACTS BETWEEN HOSPITALS AND COMMUNITY-BASED LITERACY PROGRAMS

Chapter Six provides suggestions to facilitate ties between community and hospital programs with the aim of reducing problems associated with stigmatization. It will take work and commitment to develop these ties and even more work to truly adjust community programs to accommodate these students' needs. As this student's comment makes clear, adjusting programs is not simply a matter of expressing a desire to be accepting.

> *"If I were to take Math 30 in a correspondence course or at the college, it would get too tough. Especially correspondence courses when they send all the material at once. You've got all the material staring at you at once. I can't handle that! If they'd give me one lesson at a time maybe I could do it, but not when it comes all at once like that. I just can't handle it."*

LEARNING ABOUT MENTAL DISORDERS AND TREATMENTS

Many problems mentioned in this chapter become stigmas and contribute to stereotypes about people treated for mental disorder. Drowsiness and fatigue are transformed into laziness. Hallucinations and delusions are behind 'crazy talk'. Difficulty with attention span and making realistic goals leads to the stigma that 'these people are out of it'. For this reason, if for no other, reading through all or most of the problems identified here and the discussions on medication and drugs in Chapter One is recommended.

Tardive Dyskinesia

The problem

Tardive dyskinesia (TD) is a serious, lasting side effect which occurs in one out of four people treated with antipsychotic drugs over a long period of time. This disorder appears as rhythmic movements of the upper body and the face. The person may stick-out her/his tongue, chew, or smack her/his lips. Finger movements, jiggling legs, and neck and body movements are also common. It appears well into treatment and it cannot be treated with medications. When TD occurs, doctors usually try to reduce the dosage of antipsychotic drugs, change the drugs, or stop prescribing them altogether. Recently psychiatrists have treated people suffering from TD with Clozaril. This approach seems promising, but Clozaril has other side effects which may also create problems.

Rhythmic movements associated with TD make writing and holding reading material difficult. Distractions caused by TD affects concentration for the student and those working nearby. It is also reported that TD causes deterioration of the brain centres involved with learning. Some researchers believe it is the severity of the psychotic disorder which creates impaired thinking ability; however, recent studies indicate that TD causes its own problems.

Strategies for accommodating TD

Beyond changing medications, there are no specific strategies for minimizing the adverse effect of TD on learning. Strategies suggested for dealing with tremor may be used to deal with the body movements caused by TD. Suggestions concerning attention and concentration mentioned in this chapter and Chapter Three may be helpful.

Tremors

The problem

Shaking hands are a common side effect of drugs. Tremors may occur in the arms, hands, tongue, and jaw. With antipsychotic drugs the tremors are usually slow. With Lithium (used to treat manic-depressive disorder), hand tremors can be more severe. Drugs may also cause 'cogwheel rigidity', a stiffness which begins at the shoulders and spreads to other parts of the body. It will decrease with time in 95% of the patients.

Tremors interfere with learning in obvious ways. Shaking hands make it difficult to write or hold a book. Less obvious are some social problems. A student puts it this way.

> *"People stare at me when my hands shake. I could do the work okay, but this guy keeps looking at me so I want to put the stuff away and do something else."*

An instructor reports a related problem.

> *"The students like to smoke and drink coffee during class. I don't mind. But when a student shakes, the coffee spills on the table and papers. Cigarette tobacco is spread around. We've had a few accidents with coffee that made it hard to work. I had to stop the coffee and cigarettes during class."*

Strategies for minimizing the effects of tremors

CHANGING TASKS

Since tremors usually pass, an instructor's advice to 'roll with it' is reasonable. Another recommends changing tasks. Instead of writing, students can spend more time reading, doing oral work, or working with audio-visual materials.

PROMOTING TOLERANCE

The social problems described above need to be addressed. One student thinks that talking about it with others helps them to be accepting. The important thing is to speak openly to the student about the problem and develop a strategy which meets everyone's needs.

CHANGING DRUGS

A psychiatrist suggests that tremors which cause problems for a student should be reported to the patient's doctor or nurse. Tremors can indicate improper medication. In some cases the doctor may prescribe drugs (antiparkinsonian drugs) to control the tremors.

Chapter Six

TRAINING TUTORS OF PEOPLE WITH MENTAL DISORDERS

TUTOR trainers should provide training for tutors who expect to teach special needs students. An uninformed tutor can come to the wrong conclusion about a student's behaviour, which can lead to the tutor blaming the student, or just as futilely, blaming her/himself. A tutor's account of her experience helps to illustrate this point.

> *"After four months of tutoring, his reading seemed worse. I gave him a test. I made it pretty hard so it would be clear to him that we weren't getting anywhere. I was getting pretty annoyed. Well, he failed it. He failed it badly, and that made it easier for me to show him that we weren't making any progress. He got angry. That pretty much finished it."*
>
> *"Did you know anything about his disorder?"*
>
> *"No. I learned about that afterward."*

Difficulties like this one can be avoided if time is set aside for specialized tutor training. Special training should include literacy coordinators helping tutors recognise and develop personal qualities that are necessary for effective tutoring. Through training, coordinators should help tutors create realistic goals for what they hope to accomplish. Preparing tutors to work with people confined to mental hospitals and with those who live in the community, but regularly return to the hospital for treatment, is also an important part of tutor training. This chapter suggests strategies that literacy coordinators can use for training tutors to work effectively.

Developing Personal Qualities for Effective Tutoring

A literacy coordinator who matched students discharged from a mental hospital with tutors from a community program speaks about her experiences.

> *"I can often find someone who is willing, but the match doesn't last. Either the learner gets sick or stops coming. And the tutor loses patience because she doesn't see much progress. Or the student wants the tutor to*

help him with other things. I go ahead and match them up with tutors, but to be honest, I don't know why. It rarely if ever works out, and I'm concerned that the tutors will stop tutoring if they have these negative experiences. I'm not being very understanding talking in this way, but this is the problem and I don't have much success in dealing with it."

Janet Laffey and Shelia Carlson faced similar problems when they set up a literacy program in a mental hospital and tried to staff it with volunteers. It was difficult to find people willing to tutor in a mental hospital, and many of those who did volunteer soon became frustrated and quit because student progress was too slow (Laffey and Carlson, 1988). However, not everyone has these difficulties. According to one coordinator, a great deal depends on tutors' attitudes.

"The first thing I try to find out is why the person wants to tutor. If they want to do it for their ego, they'll find more recognition working with students who don't have so many other problems to juggle. The person doesn't have to have the 'right' personality, I don't mean that. It's more a sense that they are willing or able to develop attitudes which they'll need if they are to do a good job."

Here are some of the qualities which literacy coordinators will want to help tutors develop.

The ability to be self-rewarding

Tutors must learn to 'pat themselves on the back'. They should understand that poor self-esteem and preoccupation with self are characteristics of several mental disorders. Psychiatrists speak of 'flat affect' to describe the lack of emotional response which is characteristic of schizophrenia and major depression. If students fail to express enthusiasm for their accomplishments and to show appreciation for their instructors' efforts, this may not be a sign that the students do not care and are not pleased. Tutors must recognize this and develop their own abilities to be self-rewarding.

The ability to tolerate frustration

Several mental disorders and the drugs used to treat them impair memory (see Chapter Three). This creates frustration for tutors and students, and so it is essential that tutors develop their abilities to be patient, and that they assist their students in developing patience. Students get nervous and embarrassed because they cannot remember what they just learned or what they once knew. As well, students need to feel comfortable working at their own pace. This will be difficult to achieve if the tutor gets frustrated too. One tutor puts it this way.

"I used to explain things just once and then I realized that didn't do

it. I have to go over things many times to be sure he understands."

"How did it make you feel?"

"Pretty up-tight. Quite frustrated because I felt it was useless. I'd often come away thinking I was wasting my time. As we kept working together, I was able to change my expectations. I had to judge what we were doing by what he wanted to get out of this. It just took a lot of patience."

The ability to ask for help

A very important skill to develop is the ability to go to others for advice and support. People who think they can do it alone are likely to stop tutoring and say it cannot be done. This literacy coordinator describes her experience with one tutor who found it difficult to ask for help and with another who willingly discussed her problems and sought out advice.

"I kept asking her if everything was okay, and she'd say it was, but it wasn't. I could see something was wrong in the way the student acted about coming to school. Another volunteer talked about the things she had problems handling and we'd come up with ideas. The student seemed to feel pretty at ease with her and you could see why."

The ability to be flexible

No skill is more important than flexibility. Hundreds of examples could be offered to illustrate the importance of this ability. One good example is adjusting to a common problem many students face: students repeatedly going back to the hospital because they 'are sick' or their medications no longer work.

Repeated hospitalizations create several problems which demand tutor flexibility. If the student wants to continue studying while hospitalized, will the tutor be able to get to the hospital? Will the tutor be available when the student has time to study? If the student prefers to wait until she/he is released from hospital, will the tutor be able to wait? If it is not possible to predict how long the student will be in the hospital, and if it is not known whether or not she/he will want to resume her/his lessons, can the tutor wait until these things are known? If there are repeated disruptions caused by hospitalization, will the tutor be able to retain a positive attitude about working with this student?

Box 31 suggests what a tutor, student, and literacy coordinator can do to prepare for repeated hospitalizations. Planning ahead may help to avoid unnecessary disappointments, but planning alone will not solve the problem. Flexibility seems to be the key which makes plans work.

Box 31

Planning for Flexibility

Being prepared for readmissions to a mental hospital and other likely changes in the student's life can help tutors to be flexible and more accepting. Planning begins by talking to the student in order to identify changes which are likely to occur. If readmission to a hospital is expected, the tutor or literacy coordinator should make arrangements so that everyone agrees to a course of action. During a discussion of possible arrangements, these questions should be raised.

1. Suppose the student stops coming to class. How will the tutor know what has happened?

2. Based on past experiences, can the student predict if she/he is likely to return to a mental hospital? Are other changes predictable (e.g. a move to another city)?

3. Should the tutor wait to hear from the student or is there someone the tutor can contact for this information?

4. If a contact person is used, can the student introduce the tutor to the contact person beforehand so everyone can agree on when the tutor should contact this person?

5. Based on past experience, can the student predict if she/he will be able to continue studying while in the hospital?

6. Is it likely that the tutor will need to wait a long time before the student will be ready to resume her/his studies?

7. Can they arrange a specific period of time for the tutor to wait before the tutor asks to be matched with another student?

The ability to show tolerance for the student's treatment

Tutors have their own opinions about different treatments. It is not unusual for a tutor to dislike drug therapy or to believe that certain treatment programs are cruel. For the tutor to take a stand on these issues may seem like the right thing to do, but as this student's comment shows, they can create unforeseen problems.

> *"We're in a program where you get tokens for participating. The tokens are like a payment. The teacher didn't like to give us tokens because he hated the way they were used in the program. So he didn't. Then we didn't have tokens to spend. So we got short-changed. That's why people stopped going to his class."*

An instructor working in a mental hospital makes this point.

> *"This is a phoney place. Everyone is under close observation. I don't think these people get much relief from someone making judgements about them. To tell you the truth, the best thing you can do for your stu-*

dents is give them a place where there is some tolerance for different points of view. I try to keep my opinions to myself, not because I'm afraid to speak out but because I really don't think these fellows need to hear another opinion. So I teach."

Not everyone who tutors students will be self-rewarding, patient, and have these other qualities. In fact 'having them' is not the point. When matching a tutor with a student, the literacy coordinator and the tutor need to be aware of these and other qualities (See Box 32) and then work together to develop them.

Box 32

Qualities to develop for working effectively with students being treated for mental disorders

Adopt a community perspective

Remember to see the person you are working with as more than a student. She/he is also a worker, a parent, a friend, a lover, and more.

Respect value differences

Learning how to respect another's values and not using your position as an instructor to force your values on a student is an important skill to learn. This doesn't mean that instructors should tolerate racist, sexist, or other hateful remarks. Tolerance doesn't mean accepting the unacceptable. It does mean that teaching isn't preaching. Tutors must use good judgement when it comes to tolerating value differences.

Avoid self-blame and 'blaming the victim'

When instructors and students fail to solve a problem avoid focusing on who is to blame. Keep your attention focused on the problem and how to solve it. Develop the ability to say that you don't know the answer and to ask others for help. Then ask.

Creating Realistic Expectations and Goals

During the training course, literacy coordinators should emphasize that literacy education is more than learning to read and write. Literacy is a tool for self-fulfillment and greater participation in society. As one coordinator put it, "We've lost the idea of education when we only emphasize how to read and write." Her point must be given added emphasis when tutors are being trained to work with students being treated for mental disorders. An instructor puts it this way.

"I think it's hard for us to judge progress. Sometimes you feel like you're accomplishing nothing because they aren't learning how to read and write. With the drugs and their illnesses, they forget a lot. But I don't think that's

all there is to it. Some students know that somebody cares. They can talk to us and sometimes I use what they say in my lessons, but not always."

Another tutor describes how she became frustrated because so little time was spent reading and writing.

"I don't think that I had any real expectations as a tutor. I answered an ad in the paper and took the training course. When I heard they needed tutors at the hospital, I volunteered. I just thought something should be done to help these guys learn how to read. But after a while I got really frustrated because my student wasn't learning much. We spent more time talking about his problems than working in the book."

A coordinator picks up on the same theme.

"We need to think of literacy as more than just teaching skills. On the other hand, it can't become everything but teaching them. And that's what happened when we started working with this student from the hospital. The tutor got really tired of listening to his problems. After a while she stopped preparing lessons because they never got around to doing them. It's great to talk about self-esteem, but most tutors want to teach people how to read. It can't be just discussions."

Another trainer notes:

"I used to tell tutors that if they had this problem they should negotiate with the students and set aside 5 or 10 minutes out of an hour to talk and the rest to read and write."

These comments help to describe the problems tutors may face when trying to establish realistic expectations for what they want to achieve. We can see that there are no simple solutions. Coordinators will continuously wrestle with these issues. To help in this task, Box 33 has a list of goals based on the comments of experienced instructors. For a tutor training session, make an overhead transparency or photocopy Box 33 and discuss the value of these goals. Consider how tutors might pursue these goals and the stumbling blocks that might get in the way.

For instance, consider 'Teaching self-confidence'. For students, confidence comes with success. In one program, an instructor purposely places students below their achievement level so they experience success and become comfortable in a class atmosphere before progressing to new and more difficult material. Good teaching skills are needed for establishing the right place to begin. Beginning far below the student's ability may insult the student; if too high, the student experiences defeat and frustration. A tutor may suggest using tests to assess student achievement and begin at or just below the level determined by the assessment. However, testing can undermine self-confidence and

Box 33 — Goals

Teaching self-confidence

"He hasn't been in school for a long time and when he was there, it wasn't a pleasant experience. Now he's an adult and on top of it there's this illness and all the stuff with the hospital. I think it's important to help him gain some confidence in himself as a student. That's harder to do than learning a few more words to spell, and a lot more useful in the long run."

Supporting independent living

"I'm also helping her to learn how to live in the city again. She's been in this hospital for almost ten years. I think coming to school is the closest thing she has to the real world. That's because I'm not a nurse or a guard. So one of my goals is helping her to stay out of the hospital as much as she can."

Creating a focus

"Don't you think having a good conversation is part of literacy? I do. You can't consider it a waste of time when you're talking about things she's interested in. We read about these things, too. But a lot of what she's interested in talking about isn't written at a level she can read. So we talk about them. If I can relate it to the lesson that's great. Sometimes the talk is the lesson. We'll stay focused on the topic. Doing that becomes my goal for the lesson."

Rethinking what is meant by progress

"The teacher's morale gets pretty low when someone comes along and wants to know what progress we're making. It's very hard to judge progress. Last week he told me he comes in here because somebody cares. We learn a few words, the next day most of them are lost. But he comes back every day and slowly we're getting somewhere. He has time. He isn't in a hurry. He sees it as progress; so I have to learn to work at his pace."

Making each day count

"I used to think that I had to get my student through a course. That just got me frustrated. It didn't have anything to do with the student. Just after we started the ward changed it's schedule and we had to change ours. Now I try to make what we do each day count."

may not reflect what a particular student can actually accomplish.

Briefly put, the task of helping students to improve self-confidence requires practice and sensitivity. Use role playing in tutor training so that tutors can practice administering an assessment test or beginning a student at a level which allows for success and should improve confidence. If encouraged to do so, tutors will widen their own horizons about what they wish to achieve. Having an opportunity to dis-

cuss their goals is an important part of that process.

As a final comment on goals, what this literacy coordinator has to say must be taken seriously, not because we want to end on a note of gloom, but because we must recognize the difficulty tutors will face on this important issue and the crucial role tutor training plays in supporting their efforts.

> *"The truth? Tutors get fed-up because they want to teach skills and the students need something more than this. I'm not convinced that the tutors are the ones who should be trying to meet these other needs. Also, I'm not convinced that putting aside learning to read and write and still calling it literacy is a good idea. I think it can be a way to avoid making some tough decisions. You have to try to keep on track and when that seems impossible, you have to be prepared to ask yourself if this is the right thing for this person to be doing at this time. I have to be there to help the tutor ask this question."*

Preparing Tutors to Work in an Institution

Many students are confined to mental hospitals so tutors will find themselves teaching in these settings. Community-based instructors are also likely to have contact with hospitals. While they may only see students who live in the community, many adults move in and out of hospitals depending on the nature of their disorders and treatments. The tutor may not realize how much influence the hospital setting has on a student's daily life. In order to come to a lesson, the student may have to juggle her/his appointments with a psychiatrist, community nurse, or social worker. Tutors can make this much easier by knowing something about the hospital, the responsibilities of mental health workers, and their student's various therapy programs. Chapter Two provides essential information about the mental heath system.

In this section we describe a four step plan for introducing tutors to hospital staff and hospital routine. This is followed by a strategy for improving communication between tutors and hospital staff.

A four step plan for preparing to teach in institutions

STEP ONE: CREATE AWARENESS AND IDENTIFY INTEREST

During the initial interview with a person who wishes to tutor, the literacy coordinator or trainer can mention that on occasion the need arises for tutors to work with adults who have special needs, for example, students being treated for mental disorders. Ask if the tutor would be interested in teaching these students. During the tutor training session this might be raised again to keep tutors aware of the need. The literacy program may not have a request for a special needs tutor at the time, but requests are often made and the program coordinator wants to be prepared to provide a tutor.

STEP TWO: ARRANGE FOR A DISCUSSION GROUP AND PREPARE FOR A VISIT TO AN INSTITUTION

If a nearby hospital has a school program, the coordinator should speak to the instructor and arrange a time when the instructor can attend a training session and make a presentation there. Use this comment from the coordinator of a literacy program in a prison to help plan the instructor's presentation.

> *"I'd like to visit the instructor first to meet with the tutors and discuss what our school tries to do and what our needs are. We can talk about the students here and the issues which come up. I think one or two tutor trainees who weren't interested might be after they hear a bit about our work. Then let the trainees come out and see what we do in the school at the hospital."*

If the hospital does not have a school program - or even if it does - invite people from a local self-help group to cooperate in the planning of a presentation. People from self-help and community groups, patients' advocates, and mental health workers are valuable resources.

By participating in the training session, representatives from the hospital will become aware of the role community-based literacy programs can play in the lives of adults being treated for mental disorders. Contact the Canadian Mental Health Association Divisional Office nearest you for information about groups in your area. See the Resource Guide in this handbook for a list of these offices.

STEP THREE: VISIT THE INSTITUTION

Following the discussions at the tutor training centre, ask for volunteers who would be interested in visiting the hospital. Remember when doing this that many people have never been inside a mental hospital before. They may have no idea what to expect, or their expectations may be based on television and films. For this reason, it is worth stressing the value of the visit. The director of a school had this to say about its value.

> *"Visiting might help them gain an appreciation for the difficulties these students must overcome. It's a chance for them to meet the students on their own ground and to see for themselves what many of them have had to overcome.*
>
> *"Something else. You'd be surprised how often people don't realize how physically isolated we are from the city. I met a lovely person who was really eager, but he didn't realize the distance and how he would have to allow for winter driving conditions."*

Most prisons require a security clearance for each visitor. These are not difficult to obtain if tutors do not have criminal records. Your contact person in the institution should be able to arrange for the clearance. Mental hospitals do not require security clearances.

If it is not possible to visit a mental hospital and speak with the instructor and

students in the school program, use the Resource Guide in this handbook to locate films and other support material which will help tutors to appreciate the student's experiences in an institutional setting.

STEP FOUR: HAVE A FOLLOW-UP DISCUSSION

After the visit arrange a follow-up meeting to provide tutors with an opportunity to discuss their perceptions and reactions. Invite those who did not visit the institution to attend this meeting. Those who did not visit the hospital may learn from this meeting that teaching students with special needs is something they would like to reconsider.

Preparing to work with the student and mental health staff

Before the tutor actually begins to work with a student, certain preparations are essential. By following these three steps, some, if not all, difficulties can be averted.

STEP ONE: CONFIRM STUDENT'S COMMITMENT AND STAFF COOPERATION

The literacy coordinator should speak to the student in order to confirm her/his desire to work with a tutor. Once this is established, the tutor should be told to call the hospital before she/he leaves home to confirm that the student will be available for a lesson. It is also worthwhile to ensure that a staff member at the hospital - or a community nurse if the student lives in the community - will take some responsibility for helping to make the match work. For instance, if at the last minute something happens which will prevent the student meeting with the tutor, who is going to inform the tutor that the lesson is cancelled? An instructor with success in matching tutors in a hospital setting highlighted these points.

> *"Students must understand that the tutor is going to be coming to the hospital for them. This might mean they are coming some distance and so the student must be ready to make a commitment. And either someone on staff or I must be prepared to notify the tutor if the student can't come to school. This is very important. In institutions like this things can change quickly. You don't always know ahead. The tutor needs to know this, and the students and staff need to realize it and be prepared to inform the tutor if they can."*

A tutor comments about what can happen when the commitment is not there.

> *"We had a lot of attendance problems, and they weren't all his [the student's] doing. I'd come out and he wouldn't be around. I'd call the ward and it would take them 20 to 45 minutes to get him down to this room. And they wouldn't let me come to the ward and get him. I came out to work with him more than once and he couldn't come. Nobody bothered to let me know. So I stopped coming and I don't think I'd do it again."*

You must also realize that hospital staff work in shifts and these shifts rotate. Just

Box 34

Topics to discuss for preparing to work with students

1. Should students be required to disclose their mental disorder and treatment? Do we need this information?
2. How much information about mental disorders and medications do we need to know?
3. Which disorders and drugs affect students' learning abilities?
4. Is there such a thing as being 'too sick' to participate in a literacy program? If so, how are we to know when that limit is reached?
5. Are psychiatric patients dangerous? How can we tell whether they are?
6. What if hygiene becomes a problem?
7. Can we teach in a small group? How should we organize the group to allow a student to leave if necessary?
8. What special study supports are needed?
9. Can we use assessment tests?
10. Suppose the student wants me to become her/his advocate. What should I do? Should we be teaching students about mental disorders and medications?
12. What are patients' rights? How will this affect our working together?
13. Just how important is literacy going to be for the student? Won't she/he have more pressing issues?

when the coordinator and the tutor are well-known by one group of staff, the shift changes and there is no guarantee that people on the new shift are prepared to make the same commitment as the others. You will need to work this problem out. Learn when shifts change. When they do, be prepared by contacting someone in charge to make them aware of your tutoring arrangement. Above all, be flexible but firm while taking the time to get the schedule working again.

STEP TWO: MEET WITH THE STUDENT AND STAFF TO ARRANGE A SUPPORT NETWORK

Getting to know people who are significant in a student's life will improve the learning experience. This networking may be helpful in the event of an unplanned change in the student's routine or health. With prior notice, a contact person can notify the tutor if changes occur. A simple telephone call can avoid unnecessary misunderstandings.

STEP THREE: AN ORIENTATION TOUR IS A MUST

If a good match is important, make sure that the tutor completes this last important step: a tour of the hospital to gain some appreciation of the size and complexity

of the place and to meet people who know the student as a patient. This instructor's experience helps to explain why this is so important.

> *"I was working in the dark. I'd give her homework because she asked for it, but it never got done. I was pretty suspicious. Then I had an opportunity to go to the unit. Well, there really wasn't any place to do homework. It was pretty noisy, especially the T.V. And I know she has problems concentrating and she gets restless, so working there, you could forget it. If I'd looked around before, I would have had a much better sense of things and we might have gotten along much better. So I think you should encourage anyone teaching in a place like that to take a tour of the place first."*

Box 34 contains a list of topics which may be raised during a tutor training session on working with adults being treated for mental disorders. Information on each of these topics is to be found in this handbook. Additional information is available through the materials listed in the Resource Guide.

WORD LIST & GLOSSARY

THIS section is divided into two parts. The first part provides a list of technical words used in the handbook. Following each word is the page number where the word and its definition can be found. The second part is a glossary of additional terms that occur frequently in conversation and written material concerning mental disorders. For terms not listed here, two good places to look are:

THE AMERICAN PSYCHIATRIC ASSOCIATION'S PSYCHIATRIC GLOSSARY,
published in 1984 by the American Psychiatric press, Inc.
1400 K Street, N.W. Washington, D.C. 20005.

ARTHUR S. REBER'S THE PENGUIN DICTIONARY OF PSYCHOLOGY,
published in 1985 by Penguin Books,
2801 John Street, Markham, Ontario L3R 1B4.

Word List

This word list refers to the place in the handbook where the word is defined.

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Glossary

This is a glossary of selected terms which occur frequently in discussions and written material on mental disorders.

acting out
Physical expressions of emotional conflicts. The person is not aware of the meaning of her/his action.

aggression
Forceful action, usually physical or spoken. Aggression may or may not be appropriate. It may be directed outward toward someone or something or inward toward the self.

akathisia
Restlessness as a side effect of some medications.

akinesia
Rather zombie-like movement which may be a side effect of medications.

Alzheimer's disease
A degenerative disease which affects the nervous system and causes dementia.

American Psychiatric Association (APA)
A major professional organization which promotes research in psychology.

amnesia
A loss of memory which may be limited to certain kinds of memory or for a certain length of time.

attention
The ability to focus on a given task. Attention involves arousal, length of attention, and distractibility. Arousal is the ability to respond to some stimuli. Length of attention refers to the amount of time a person can focus on a task. Distractibility refers to the ability to sustain attention faced with competing stimuli.

aversion therapy
A form of behaviour therapy in which the person learns to connect a punishment with some unwanted behaviour.

barbiturates
Drugs which slow down the central nervous system.

bipolar disorder
A mood disorder in which the person swings between depression and mania. Also called manic-depressive disorder.

catatonia
A form of schizophrenic disorder in which the person's body is very rigid or the person moves and speaks wildly.

catchment area
A geographic area for which a hospital or clinic has responsibility.

central nervous system (CNS)
The brain and spinal cord.

chemotherapy
The use of drugs to treat a mental disorder.

chronic
Something which lasts for a long period of time, as opposed to something which happens once and goes away.

cognitive
A term which refers to thinking and includes making decisions, reasoning, and imagining.

cognitive therapy
A type of therapy that teaches new beliefs, thoughts, and feelings.

commitment
A legal process of putting someone in a mental hospital, usually against her/his will.

community psychology
A branch of psychology which tries to correct social conditions which cause mental disorder.

conditioning
A learning process in which reward or punishment leads to a new response.

congenital
Some condition that is present at birth.

Diagnostic and Statistical Manual of Mental Disorder IIIR (DSM
The third, revised edition of the American Psychiatric Association's official classification of mental disorders. The manual is widely used to diagnose mental disorders. The fourth edition (DSM IV) has been published.

dyslexia
Inability or difficulty reading. Frequently used as a synonym for or explanation of a learning disability.

epilepsy
A disorder characterized by occasional physical and sensory seizures, which may be accompanied by loss of consciousness. The cause may be organic or undeterminable.

extrapyramidal side effects
Unwanted effects caused by drugs used to treat mental disorders. They include drooling, muscle rigidity, restlessness, and tremors.

geriatrics
A branch of medicine dealing with aging and diseases of aging.

halfway house
A transitional, supervised residence outside of an institution which facilitates re-entry into the general community for former patients of mental hospitals and former prisoners.

holistic
An approach to treatment which considers the person in totality, as contrasted to treatments which focus only on a psychological or physical problem.

hyperactivity

Excessive physical activity frequently, but not always, related to stress, tension, or an emotional disturbance. It also may be a side effect of drugs.

insanity

An obsolete but still popular term for mental disorder. Until quite recently the term was used in a legal context (i.e. the insanity defence).

intelligence

The capacity to learn and to utilize appropriately what one learns.

intelligence quotient (IQ)

A numerical rating of intelligence determined by psychological tests. The most frequently used test is the Wechsler Adult Intelligence Scale (WAIS).

multiple personality

A term used for a person who adopts two or more personalities. The psychiatric term is dissociative disorder.

nervous breakdown

A frequently used popular term for mental disorder.

neurosis

A term for mild, maladaptive behaviour, compared to psychosis.

personality disorders

Chronic, inflexible, maladaptive patterns of behaviour which are difficult to change because the person does not think of herself or himself as disordered. Psychiatrists subdivide personality disorders into many types. Some of these are:

- **antisocial**

Behaviour patterns which bring a person repeatedly into conflict with others; antisocial people are often easily frustrated, irresponsible, callous, and incapable of loyalty to others.

- **borderline**

Unstable moods and self image, impulsive, marked shifts in attitudes, and frequently unpredictable behaviour.

- **compulsive**

Difficulty expressing emotions, a preoccupation with details, rules, and order, and excessive devotion to some activity to the exclusion of pleasure.

passive aggressive

Aggressive behaviour expressed without any overt signs of aggression. The person may show aggression by obstructing progress, pouting, and procrastinating.

placebo

A drug which is identical in appearance to another drug, has no chemical agents, but may cause physical or emotional changes as though it did have active ingredients.

psychosomatic

Used to refer to physical illnesses in which the cause of the illness is not physical but an emotional conflict.

reality testing
The ability to obtain an accurate picture of events and interact with them, and the ability to distinguish between a personal point of view and the opinion of others. Used as a 'test' of psychosis.

regression
For a brief moment or an extended period of time, a person returns to a more childlike pattern of behaviour.

repression
An unconscious mental defence mechanism in which the person blocks the memory of unacceptable and painful memories, ideas, and fantasies.

senile demential
A continuous deterioration of memory, judgement, attention, and other higher mental functions. While it is not due to aging, senile dementia is most often associated with old age.

stupor
A state in which a person does not react and is not aware of her/his surroundings.

tic
A physical expression of an emotional conflict which takes the form of occasional, involuntary movements, for example, a twitching eye or a tapping foot.

unipolar psychosis
The term used by psychiatry to refer to major depressive disorder.

RESOURCE GUIDE

While this is by no means a complete list of available materials and organizations, this resource guide will be useful for adult educators who wish to have more information on the topics covered in the handbook.

Printed Resources

Books and articles on mental disorders and treatments

After the door has been opened: Mental health issues affecting immigrants and refugees in Canada. 1988. Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. Ottawa: Health and Welfare Canada.

Bloor Spadina Club. 1988. *Minds in progress.* Toronto: Community Resources Consultants of Toronto.

Chamberlin, Judi. 1978. *On our own.* New York: Hawthorn Books.

Church, Kathryn. 1986. *From consumer to citizen.* Canadian Mental Health Association.

Cozens, Jenny. 1988. *Nervous breakdown.* London: Piatkus.

Endler, N. 1982. *Holiday of darkness.* New York/Toronto: John Wiley & Sons.

Hutchison, Peggy, et al. 1985. *Listening to people who have directly experienced the mental health system.* Canadian Mental Health Association.

Hutchison, Peggy, et al. 1986. *Participating with people who have directly experienced the mental health system.* Canadian Mental Health Association.

Jeffries, J. J., et al. 1990. *Living and working with schizophrenia.* Toronto: University of Toronto Press.

Lithium and manic depression: A guide. 1984. Lithium Information Center, University of Wisconsin, Madison.

No repeats: A book about women and prescription pills. 1990. Kingston: AWARE (Action on Women's Addictions-Research and Education). Available from P.O. Box 86, Kingston, Ontario K7L 4V6.

Pape, Bonnie, and Kathryn Church. 1987. *Community reinvestment: Balancing the use of resources to support people with mental disabilities.* Canadian Mental Health Association.

Rush, J. 1983. *Beating depression.* Toronto: John Wiley and Sons, Canada Limited.

Torrey, E. F. 1983. *Surviving schizophrenia: A family manual.* New York: Harper and Rowe. Distributed in Canada by Fitzhenry and Whiteside.

Weitz, Don, and Bonnie Burstow, eds. 1988. *Shrink resistant: The struggle against psychiatry in Canada.* Vancouver: New Star Books.

Books, articles, and organizations on teaching adults being treated for mental disorders

These resources were written to provide information for adult educators working with students being treated for mental disorders. While they do not cover as much information as the handbook, their different perspectives provide worthwhile supplementary information.

CENTER FOR PSYCHIATRIC REHABILITATION

The Center for Psychiatric Rehabilitation is very active in meeting the needs of students being treated for mental disorders. The Center provides support for students attending Boston University, conducts research on treatment and participation in all types of adult education, and publishes material written for teachers. For a complete list of their publications write to Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professionals, Boston University, 750 Commonwealth Avenue, Boston, Massachusetts 02215.

GOOD SAMARITAN HOSPITAL

This hospital publishes articles, booklets, and other materials for teachers working with students suffering from traumatic brain injury. Examples of their material include the pamphlets *Traumatic brain injury: Educational aspects* and *Executive function compromise following traumatic brain injury in school-age children.* Write to Good Samaritan Community Healthcare, P.O. Box 1247, Puyallup, Washington 98372.

NATIONAL HEAD INJURY FOUNDATION, INC.

This foundation publishes materials useful to teachers, although the emphasis is on children being treated for brain injury. Two examples of publications are *Re-entry: The head injured student returns to school* by R. C. Savage, and *An educator's manual: What educators need to know about students with traumatic brain injury.* For copies write to the National Head Injury Foundation Task Force on Special Education, 333 Turnpike Road, Southborough, Massachusetts 01772.

ADDITIONAL MATERIAL

Dougherty, P. M., and M. V. Radomski. 1987. *The cognitive rehabilitation workbook.* Rockville, Maryland: Aspen Publication.

Goldgrab, Sheila. 1991. "Psychiatric patients in London Psychiatric Hospital's literacy programs and their preparation for independent living." In *Issues in adult literacy and basic education: Canada.* Edited by James Draper, Maurice Taylor, Sheila Goldgrab. Toronto: OISE Press.

Lavender, Peter. 1985. "Singer and listener: Basic education work with the mentally ill." *Viewpoints.* 2(February 1985):5-10.

"People with a history of mental illness or emotional problem." 1991. In *The literacy book* (draft). Toronto: Centre for Independent Living Toronto.

Redirection through education. No date. Toronto: Community Services Division, George Brown Community College. Redirection Through Education is a community mental health program that operates within George Brown City College. It offers social, educational, vocational, and recreational

support to individuals returning to the community after being hospitalized for emotional or mental disorders. Contact Redirection Through Education, George Brown City College, Nightingale Campus, Room 528 - 2 Murray St. Toronto, Ontario M5T 2T9. (416) 867-2000.

Riester, A. E., H. Scholz, and E. S. Rhem. *Goals, objectives and teaching strategies for emotionally disturbed students by diagnosis (DSM-III-R).* This booklet is available by writing to the Southwest Neuropsychiatric Institute, 8535 Tom Slick, San Antonio, Texas 78229.

Rogers, Julia. 1965. *Am I welcome here?: A book about literacy and psychiatric experiences.* Toronto: Christopher House Adult Literacy Program.

WEA. 1985. *Experiences of a changing kind: Adult education in psychiatric hospitals and day centres.* Introduction by J. Donovan. London: Workers Education Association.

Books, articles, and newletters on services and support for people being treated for mental disorders

Anthony, W. A., and M. Farkas. 1989. *Psychiatric rehabilitation: Programs and practices.* Baltimore: John Hopkins University Press.

Community Support Network News. This newsletter is published monthly by the Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professionals, Boston University, 730 Commonwealth Ave. Boston, Massachusetts 02215

Trainor, J., and K. Church. 1984. *A framework for support for people with severe mental disabilities.* This booklet is published by the Canadian Mental Health Association. Write to 2160 Yonge Street, Toronto, Ontario. M4S 2Z3

Consumers' guides to medications

These consumers' guides provide extensive information on all prescription drugs commonly in use, including drugs used to treat mental disorders. They describe the drug's benefits, common uses, when the drug should not be used, side effects, and special precautions. These books can be found in the reference section of most college and university libraries and may be available through public libraries.

Advice for the patient: Drug information in lay language. 1992. New York: United States Pharmacopeial Convention, Inc. (USPC).

Appleton, W. S. 1988. *Practical clinical psychopharmacology.* 3rd edition. Baltimore: Williams & Wilkins. This guide is written for mental health workers, but is useful for consumers and adult educators.

Long, J. W. 1991. *The essential guide to prescription drugs.* New York: Harper Perennial.

Preston, J., and J. Johnson. 1990. *Clinical psychopharmacology made ridiculously simple.* This brief guide to the use of drugs was written for professionals, but may be useful for adult educators.

Dictionaries on mental disorders and treatments

American Psychiatric Association. 1984. *Psychiatric glossary.* Washington, D.C.: The American Psychiatric Association. This glossary has over 1,000 terms, including definitions of disorders, descriptions of drugs and other treatments, definitions of legal terms, and information on street drugs.

Kreutzer, J.S., and B. Lent. "A glossary of cognitive rehabilitation terminology." *Cognitive Rehabilitation*, May 1986. This glossary is available through libraries which subscribe to the journal *Cognitive Rehabilitation*.

Reber, A. 1985. *Penguin dictionary of psychology*. London: Penguin Books. This dictionary covers most terms used in the field of psychology. It does not list the different medications, but it does define most mental disorders, forms of treatment, schools of thought, and theories of behaviour and learning. The dictionary is sensitive to controversial issues in the definition and treatment of mental disorders.

Legal and ethical issues

Bill C-30: An act to amend the criminal code (mental disorder). April 1992. *Health Law Review*. 1(2).

Burstow, B. 1983. "Psychiatric patients' rights in Ontario: An explanation of the Mental Health Act." *Phoenix Rising*, 4(1):27-33.

Robertson, G. B. 1988. *Mental disability and the law in Canada*. Toronto: Carswell.

"Women and Psychiatry". February 1985. *Phoenix Rising* 5(1).

Newsletters and magazines

OPSA newsletter. Available from Ontario Psychiatric Survivor's Alliance, 3107 Bloor St. West, Suite 201, Etobicoke, Ontario M8X 1E3.

Phoenix rising. (out of print magazine). Back issues available by calling Toronto, Ontario(416) 583-7103.

Newsletters are also published by several self-help groups and organizations listed in this guide under "Organizations and Self-help Groups."

Pamphlets on mental disorders and treatments

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

The APA writes and publishes a series of pamphlets on mental disorders. Each pamphlet describes the 'symptoms' of the disorder, its causes, and medical treatments. A list of additional literature is included along with the names of organizations and support groups in the United States. The perspective of all APA material is that mental disorders are diseases. For copies of these pamphlets write to: American Psychiatric Association, 1400 K Street N.W., Washington, D.C. 20005.

Let's talk facts about anxiety disorders

Let's talk facts about depression

Let's talk facts about manic-depressive disorder

Let's talk facts about mental illness: There are a lot of troubled people

Let's talk facts about phobias

Let's talk facts about substance abuse

CLARKE INSTITUTE OF PSYCHIATRY

The Clarke Institute publishes the following series of booklets. Each booklet defines the disorder and describes the common treatment methods. This is followed by a section called 'Frequently Asked Questions' and a list of suggested readings for the general public and mental health workers. These booklets can be purchased by writing to: Social Work Department, Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario M5T 1R8.

Kerr, A., R. Thompson, and J. Jefferies. 1988. *A guide for patients and families: Schizophrenia.* Toronto: Clarke Institute of Psychiatry.

Scholz, H., and T. Krupa. 1987. *A guide for people recovering from psychiatric illness: Vocational rehabilitation.* Toronto: Clarke Institute of Psychiatry.

Thompson, R., H. C. Stancer, and E. Persad. 1987. *A guide for patients and families: Depressive illness.* 2nd edition. Toronto: Clarke Institute of Psychiatry.

Thompson, R., H. C. Stancer, and E. Persad. 1987. *A guide for patients and families: Manic-depressive illness.* 2nd edition. Toronto: Clarke Institute of Psychiatry.

Textbooks on mental disorder

These textbooks were written for undergraduate university courses in abnormal psychology. They are readable without extensive background in psychology, and they provide extensive information on mental disorders and treatments not covered in this handbook. For example, they contain information on personality disorders, organic disorders, mental retardation, and a wide range of therapies.

Bootzin, Richard, and Joan Acacella. 1988. *Abnormal psychology: Current perspectives.* 5th edition. New York: McGraw-Hill.

Meyer, R. G., and P. Salmon. 1988. *Abnormal psychology.* 2nd edition. Allyn and Bacon, Inc.

Sue, David, et al. 1989. *Understanding abnormal behavior.* 2nd edition. Boston: Houghton Mifflin Co.

Films and Videos

Alternatives to hysteria (1977)
Video 27 min. col. 3/4" cassette
A look at the Canadian mental health system framed by one woman's analysis of her own mental breakdown and subsequent treatment.
Distr: Vancouver Women in Focus, DEC Film and Video

Controversial research: Schizophrenia among U.K. blacks.
Documentary film available for viewing at TV Ontario. To book, call (416) 484-2600, ext. 2076.

Educable mentally handicapped (1983)
Video 17 min. 18 sec. col. study guides
Part of a series designed for educators at all levels instructing classes which include students who have learning disabilities, are mentally or physically disabled, or are gifted.
Distr: Access Network

Families dealing with mental illness (1985)
Video 10 min. col. 3/4"
Living with a mentally ill person is described as having become increasingly difficult since the introduction of legislation to protect mental patients' rights and of government policies which encourage the release of patients from hospital care into the community. These issues are discussed with a social worker and the mother of a schizophrenic.
Distr: CTV Television Network Ltd.

Fluster (1978)
Film 6 min. 9 sec. B&W 16mm
Describes a state of mind where thoughts, images, and emotions rush at us in a wild and uncontrollable manner.
Distr: Canadian Film Makers Distribution Centre

Full moon darkness (1985)
Film 90 min. B&W
A film on the controversial subject of mental illness, which forces us to realize that mental illness can touch anyone.
Distr: Canadian Film Makers Distribution Centre

House of horrors (1988)
Video 21 min. 2 sec. col.
This program investigates why the Cedar Glen Home for the Mentally Disabled continued to operate despite three years of mounting evidence of cruelty and abuse, well-known to police, local authorities, and the Ontario Ministry of Health.
Distr: CTV Television Network Ltd.

Massie (1982)
Film 24 min. 11 sec. col. 16mm
A dramatic portrayal of a young woman struggling to maintain her sanity.
Distr: Lauren Productions

Mental Patients' Association
Film 28 min. 40 sec. col. 16mm (1977)
This film shows how former mental patients and their friends formed the Vancouver Mental Patients' Association, a unique, democratically organized self-help group, to assist people during the critical post-release period.
Distr: National Film Board

Myths of mental illness (1988)
Film 56 min. 15 sec. col.
The film raises questions about coping with stressful life and work situations; mental-health and illness; psychiatry, drug therapy, and psychotherapy; the healing potential in human relationships; human freedom and dignity; technology and the invasion of privacy; and media integrity.
Distr: National Film Board

Not crazy like you think (1983)
Film 73 min. col. 16mm
A dozen people, all past or present psychiatric patients, have gathered at a house in the country for a weekend to make a film on insanity. They talk about the experience of insanity and the influence of institutions and drug therapy. The group also acts out their versions of craziness as they direct dramatic recreations of significant scenes from their own histories.

Distr: DEC Film and Video

Out of madness, people grow (1986)
Film 26 min. 50 col. 16mm
A report on a remarkable self-help movement for ex-psychiatric patients.
Distr: CBC Enterprises

Penetang, by reason of insanity (1986)
Film 26 min. 50 sec. col. 16mm
A look inside the notorious 50-year-old Penetanguishene institution for 'violent' mentally ill men.
Distr: CBC Enterprises

Right to decide (1989)
Video 13 min 30 sec. col.
Jim Reed talks to the mentally disabled, their advocates and care-givers about the dangers of legislation that, in some cases, would allow substitute consent for procedures such as sterilization and medical experiments.
Distr: CTV Television Network Ltd.

Scissere (1982)
Film 87 min. 2 sec. col. 16mm
A feature-length experimental film dealing nominally with the release of a mental patient from an institution.
Distr: Collaborative Effort Productions Company

This isn't wonderland (1982)
Film 57 min. col. 16mm
Alice is trying to steer her way through the troubled waters of depression. Her story is complemented by the thoughts of a psychiatrist and a social worker on the problems women experience and the underlying reasons for those problems, and by the testimony of women who discuss their confrontations with madness.
Distr: Vancouver Women in Focus Society

Vicky (1973)
Film 50 min. 5 sec. col. 16mm
A sequel to Twelve and a Half Cents (106C 0177 135), which dealt with the murder of two small children by their mentally disturbed mother, the story is picked up years later when Vicky is released from a mental institution. She has to accept the changes in her life in the altered outside world, but she finds her past still comes back to haunt her.
Distr: CBC Enterprises

Where's Howie? (1983)
Film 43 min. col. 16mm
In the closed off environment of a communal house, three friends try to deal with the increasing irrationality of Howie, a fourth member of the household.
Distr: Canadian Film Makers Distribution Centre

Why you, why anyone? (1988)
Video 16 min. col.
A look at the conformity that prevails within institutions. It moves the viewer through a mental health institution and shows how lives are molded by a structure that has little interest in individuality or personality.
Distr: V/Tapes

Distributors:

Access Network
Media Resource Centre
16930-114th Ave. N.W.
Edmonton, Alberta T5M 3S2
(403) 451-7272

Canadian Film Makers Distribution Centre
67A Portland Street
Toronto, Ontario M5V 2M9
(416) 593-1808

CBC Enterprises
P.O. Box 500
Station A
Toronto, Ontario M5W 1E6
(416) 975-3311 Ext 2364

Collaborative Effort Productions Company
91 Oakwood Avenue
Toronto, Ontario M6H 2V9
(416) 656-0909

CTV Television Network Ltd.
42 Charles Street East
Toronto, Ontario M4Y 1T5
(416) 928-6095

DEC Film and Video
394 Euclid Avenue
2nd floor
Toronto, Ontario M6G 2S9
(416) 925-9338
(416) 925-8480

Lauren Productions
1778 Rochester Street
Coquitlam, British Columbia V3K 2Y8
(604) 936-9643

Vancouver Women in Focus Society
204-456 West Broadway
Vancouver, British Columbia V5W 3W8
(604) 682-5848

V/Tape
183 Bathurst Street
Toronto, Ontario M5T 2R7
(416) 863-9897

Organizations and Self-Help Groups

Canadian Mental Health Association: Divisional Offices

C.M.H.A.: Yukon
1148 First Avenue
Whitehorse, Yukon Y1A 4S2
(403) 667-3326

C.M.H.A.: Northwest Territories
P.O. Box 2580
Yellowknife, Northwest Territories X1A 2P9
(403) 873-3190 FAX 873-4930

C.M.H.A.: British Columbia
Suite 405,
611 Alexander Street
Vancouver, British Columbia V6A 1E1
(604) 254-3211 FAX 254-2272

C.M.H.A.: Alberta
#328 Capital Place
9707 - 110 Street
Edmonton, Alberta T5K 2L9
(403) 482-6576 FAX 482-6348

C.M.H.A.: Saskatchewan
1810 Albert Street
Regina, Saskatchewan S4P 2S8
(306) 525-9543 FAX 569-3788

C.M.H.A.: Manitoba
2- 836 Ellice Avenue.
Winnipeg, Manitoba R3G 0C2
(204) 775-8888 FAX 775-3497

C.M.H.A.: Ontario
56 Wellesley Street West
Toronto, Ontario M5S 2S3
(416) 964-9611 FAX 964-6766

C.M.H.A.: Quebec
550 Sherbrooke Street West
Montreal, Quebec H3A 1B9
(514) 849-3291

C.M.H.A.: Nova Scotia
63 King Street
Dartmouth, Nova Scotia B2Y 2R7
(902) 466-6600

C.M.H.A.: Prince Edward Island
170 Fitzroy Street
P.O. Box 785
Charlottetown, Prince Edward Island C1A 7L9
(902) 566-3034 FAX 566-4643

C.M.H.A.: New Brunswick
65 Brunswick Street
Fredericton, New Brunswick E3B 1G5
(506) 455-5231 FAX 453-1723

C.M.H.A.: Newfoundland
P.O. Box 5788
St. John's, Newfoundland A1C 1A5
(709) 753-8550 FAX 753-8537

Depressive self-help groups in Canada

Some of these groups publish newsletters and are contacts for other groups within the same province.

Society of Depression and Manic-Depression of Manitoba
4-1000 Notre Dame Ave.
Winnipeg, Manitoba R3E 0N3
(204) 786-0987

Depressive and Manic-Depressive Ass. of Ontario
214 Merton St. Suite 10
Toronto, Ontario M4S 1A6
(416) 481-5413 FAX (416) 481-5545

Mutual Support and Education Self-Help for Manic-Depression
c/o Rosemary Faulkner, C.M.H.A.
P.O. Box 785
Charlottetown, Prince Edward Island C1A 7L9

Mood Disorders Association of British Columbia
201-2730 Commercial Drive
Vancouver, British Columbia V5N 5P4
(604) 873-0103 FAX (604) 873-3095

L'Association Quebecoise des depressifs et maniaco-depressifs
212 ouest, Boulevard St. Joseph
Montreal, Quebec H2T 2P8
(514) 948-6127 FAX (514) 270-8082

Self-Help Against Depression Inc. (S.H.A.D.)
P.O. Box 307
Cote St. Luc Station
Montreal, Quebec H4V 2Y5
(514) 684-9896

Depressive Disorders Selp-Help Group
c/o 9th floor 10050-112 Street
Edmonton, Alberta T5K 2J1

Organization for Manic-Depressives
Box 3260 Station B
Calgary, Alberta T2M 4L8

Society for Depression and Manic-Depression in Saskatchewan
P.O. Box 727
Delisle, Saskatchewan S0L 0P0
(306) 493-2384

Regina Manic Depressive Support Group
155 Hastings Crescent
Regina, Saskatchewan S4T 7N8
(306) 545-5532

Manic-Depressive Group
c/o C.M.H.A. Nova Scotia Division
1496 Lower Water St.
Halifax, Nova Scotia B3J 1R9
Attn: Jean-Pierre Galipeault

Manic-Depressive Selp-Help Group
c/o Our Place
5 Dominion St.
Moncton, New Brunswick E1C 6G4
Attn: Roger Melanson

Depression Anonymous
c/o C.M.H.A.
400 Main St.
Saint John, New Brunswick E2K 1V4
Attn: Darlene Wilson

Schizophrenia Society of Canada

Canadian National Office

Schizophrenia Society of Canada
814-75V The Donway West
Don Mills, Ontario M3C 2E9
(416) 445-8204

Provincial Offices

Schizophrenia Society of Alberta
102-2405 9th Ave. S.E.
Calgary, Alberta T2G 4T4
(403) 462-4554

British Columbia Friends of Schizophrenics
201-6151 Westminster Hwy.
Richmond, British Columbia V7C 4V4
(604) 270-7821

Manitoba Schizophrenia Society
#5-1000 Notre Dame
Winnipeg, Manitoba R3E 0N3
(204) 786-1616

Schizophrenia Society of Nova Scotia
Nova Scotia Hospital
Rm 115 Dewolfe Bldg.
Drawer 1004
Dartmouth, Nova Scotia B2Y 3Z9
(902) 465-2601

Newfoundland Friends of Schizophrenics
3 Herder Place
St. John's, Newfoundland A1A 1L9
(709) 753-8850

Ontario Friends of Schizophrenics
P.O. Box 217, Station "O"
Toronto, Ontario M4A 2W3
(416) 449-6830

Quebec Alliance of the Mentally Ill Inc.
P.O. Box 145, Station Cte-de-Neiges
Montral, P.Q. H3S 2S5
(514) 731-8059

La Federation Quebecoise des Familles
et Amis du Malade Mental
2383 Nerre Beauchemin
Sillery, P.Q. G1T 1H7
(418) 688-1723

Saskatchewan Friends of Schizophrenics
P.O. Box 305
Regina, Saskatchewan S4P 3A1
(306) 584-2620

Schizophrenia Society of Prince Edward Island
Family Support Group
c/o 70 Fitzroy Street
Charlottetown, Prince Edward Island C1A 1S1
(902) 566-3034

Schizophrenia Society
New Brunswick Family Group
c/o Place 400-400 Main Street
St. John, New Brunswick E2K 1J4
(506) 633-1705

Other Resource Guides (United States)

REPRINT CATALOGUES

Write to the Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professionals, Boston University, 750 Commonwealth Avenue, Boston, Massachusetts 02215.

RESOURCE MATERIALS

Write to the Center For Community Change Through Housing and Support, University of Vermont, Psychology Department, John Dewey Hall, Burlington, Vermont 05405.

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